



PEMGARDA REFERRAL FORM

Please fax completed referral form to
Avant Wellness, PLLC
(704) 537 - 0947
Please contact office for questions:
(704) 537 – 0909 Ext. 137

PATIENT DEMOGRAPHICS

PATIENT NAME:	PREFERRED CONTACT #
DATE OF REFERRAL:	SECONDARY CONTACT #
DOB:	ALLERGIES:
WEIGHT (kg):	HEIGHT (cm):
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH: GENDER: <input type="checkbox"/> F <input type="checkbox"/> M	CITY, STATE, ZIP:

Primary Diagnosis: Please Provide ICD-IO Code

- Z92.25 Personal history of Immunosuppression Therapy
 Z92.241 Personal History of Antineoplastic Therapy
 Z94+ Transplanted Organ and Tissue Status
 Other _____

REQUIRED DOCUMENTATION

We sent the following by fax 704 – 537 - 0947

- Patient Demographics Lab Results Medication History Recent Visit Notes

The patient has a Prior Authorization.

- Yes. Please fax it to us at 704 – 537 – 0947
 No

ADMINISTRATION CRITERIA

PEMGARDA is approved under FDA Emergency Use Authorization (EUA) for pre-exposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents (12 years of age and older weighing at least 40 kg) who

- Are not currently infected with SARS-CoV-2 and have not had a known recent exposure to an individual infected with SAR-CoV-2

AND

- Have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments AND are unlikely to mount an adequate immune response to COVID-19 vaccination.

DOSE SELECTION:

- INDUCTION: 4500 mg IV Infusion over at least 1 hour.
 MAINTENANCE: Repeat every 3 months. REFILLS: __ PRN: __

DATE of last infusion:

PRESCRIBER INFORMATION

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:
PHYSICIAN SIGNATURE:	DATE: