



A Carelon Company

PEMGARDA (PEMIVIBART) INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies: _____

Diagnosis Code ICD-10 (required): _____ **Diagnosis Description:** _____

Patient Status: New to Therapy Continuing Therapy Next Treatment Date: _____

PHYSICIAN INFORMATION

Prescriber Name: _____ Phone: _____ Fax: _____

Office Contact: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI #: _____ DEA#: _____ Tax ID: _____

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Pemgarda (pemivibart)	<input type="checkbox"/> 4500mg IV every 3 months <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: _____

Lab orders: _____ Lab Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X

Date: _____



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COMPREHENSIVE SUPPORT FOR PEMGARDA (PEMIVIBART) THERAPY

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & INSURANCE APPROVAL

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes (H&P) to support primary diagnosis
- Labs attached (if applicable)
- Diagnostics attached (if applicable)
- Medical necessity (if applicable): _____