Texas Centers for Infectious Disease Associates Pharmacy
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Date:	Ht. (in):	Wt. (kg):	Allergies:
Patient Name:		Patient Phone #:	DOB:
DX #1: Immunodeficiency		ICD 10: D81.31	Age:
DX #2:		ICD 10:	

Please also include:
Progress note stating that patient is at high risk for severe disease.
Patient demographic sheet
Medication list

Pemgarda order:

Medication:

❑ **Pemgarda 4500mg IV X1**

Please check all that apply to why your patient is at high risk for severe disease:

❑ **Age ≥65 years** ❑ **Asthma** ❑**Cancer** ❑**Cerebrovascular disease** ❑**chronic kidney disease** ❑**HIV**

❑**Chronic lung disease** ❑**Chronic liver disease** ❑**Cystic Fibrosis** ❑**diabetes mellitus, type 1or2** ❑**Obesity**

❑**Heart conditions** ❑**Obesity (BMI ≥30kg/m2) &Overweight (BMI 25-29 kg/m2)** ❑**pregnancy or recent pregnancy**

❑**primary immunodeficiencies** ❑**smoking (current or former)** ❑**sickle cell disease or thalassemia** ❑**tuberculosis**

❑**solid organ or blood stem cell transplantation** ❑**pregnancy or recent pregnancy** ❑**use of corticosteroids**

❑**use of immunosuppressive medications**

Nursing: Evaluate and assess patient status, place IV line, use SASH flushing protocol: S- Saline 10ml, A- administration medication, S- saline 10ml, H-Heparin 5ml (100units/ml). When on more than one dose per day patient to alternate lumens for administration

Presriber name: _____
NPI: _____
DEA: _____
License number : _____
Office address: _____
Office Phone number: _____

Prescriber Authorization: I authorize this pharmacy and its representative to act as my agent to secure coverage, provide supplies necessary for infusion and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent.

Prescriber signature: _____ **Date:** _____

******Digitally signed by designated physician*******
******Please Notify TCIDA immediately if patient is re-admitted to a hospital******