

## mAb Infusion Site Referral Form

**18 years old and above ONLY**

### Referring Provider Information

Provider Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
 Office Name: \_\_\_\_\_ Provider Phone: \_\_\_\_\_  
 Provider email: \_\_\_\_\_ Provider Cell: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Date of Onset of Illness (Mild to Moderate\*) \_\_\_\_\_ = \_\_\_\_\_ Day of Illness (<10)

#### **COVID Positive Treatment Criteria: Bamlanivimab and Etesevimab or Casirivimab and Imdevimab**

Check all symptoms that are present:

- |                                   |                                   |                                      |                                   |  |  |
|-----------------------------------|-----------------------------------|--------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Fever    | <input type="checkbox"/> Malaise  | <input type="checkbox"/> Nausea      | <input type="checkbox"/> Cough    | <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Dyspnea on exertion |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Muscle Pain         | <input type="checkbox"/> Shortness of breath |

Date of Testing for COVID: \_\_\_\_\_ Test Type:  PCR  Antigen

- Symptoms present less than 10 days:  Yes  No  Not Eligible  N/A
- SpO2% greater than 90% on RA:  Yes  No  Not Eligible  N/A
- If previously on home O2, has no increased need:  Yes  No  Not Eligible  N/A
- Stable for discharge home:  Yes  No  Not Eligible  N/A
- Documented positive COVID test performed:  Yes  No  Not Eligible  N/A

#### **PEP Criteria: Casirivimab and Imdevimab only**

- For post-exposure prophylaxis of COVID-19 in adult and pediatric individuals (12 years of age and older weighing at least 40 kg) who are at high risk for progression to severe COVID-19, including hospitalization or death **(see criteria below) AND**
- Not fully vaccinated or who are not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination (for example, individuals with immunocompromising conditions including those taking immunosuppressive medications) **and**
- Have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per Centers for Disease Control and Prevention (CDC) **or**
- Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, nursing homes, prisons)

\*NIH Definition: **Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have shortness of breath, dyspnea, or abnormal chest imaging.  
**Moderate Illness:** Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have saturation of oxygen (SpO2) ≥94% on room air at sea level.

### High Risk Patients Eligible for Care Who Meet One of the Following Criteria

Check below for each that meets the Monoclonal Antibody Infusion inclusion criteria:

- |   |  |
|---|--|
| <input type="checkbox"/> Older age (for example, age ≥65 years of age)  | <input type="checkbox"/> Pregnancy   |
| <input type="checkbox"/> Chronic kidney disease   | <input type="checkbox"/> Diabetes  |
| <input type="checkbox"/> Immunosuppressive disease or immunosuppressive treatment   | <input type="checkbox"/> Cardiovascular disease (including congenital heart disease) or hypertension   |
| <input type="checkbox"/> Sickle cell disease  | <input type="checkbox"/> High risk Ethnicity Groups (Latino or Black)  |
| <input type="checkbox"/> Obesity or being overweight (for example, BMI >25 kg/m2), children age 12 and up - 40 kg and in 85th percentile on growth chart  | <input type="checkbox"/> Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation, not related to COVID-19)                                       |
| <input type="checkbox"/> Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension) | <input type="checkbox"/> Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies) |
- Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19 and authorization of monoclonal antibodies under the EUA is not limited to the medical conditions or factors listed above.**

### Monoclonal Antibody Infusion Prescription Order:

- Monoclonal Antibody Therapy: Please infuse a dose of available monoclonal antibody according to the EUA.**

Prescriber Name: \_\_\_\_\_ Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Referral Line: (816)404-0829  
 or Fax 1(816)-404-2275**