mAb Infusion Site Referral Form

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 Eteseviman or Casirivimab and Imdevimab**

Check all symptoms that are present:

☐Fever	☐Malaise	☐Nausea	☐Cough	☐Loss of taste/smell	☐Dyspnea on exertion
☐Headache	☐Vomiting	☐Sore Throat	☐Diarrhea	☐Muscle Pain	☐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:

☐ Older age (for example, age ≥65 years of age)
☐ Chronic kidney disease
☐ Immunosuppressive disease or immunosuppressive treatment
☐ Sickle cell disease
☐ Obesity or being overweight (for example, BMI >25 kg/m2), children age 12 and up - 40 kg and in 85th percentile on growth chart
☐ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
☐ Pregnancy
☐ Diabetes
☐ Cardiovascular disease (including congenital heart disease) or hypertension
☐High risk Ethnicity Groups (Latino or Black)
☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation, not related to COVID-19)
☐ 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: 660-829-6647

Email completed form to MOreferrals@sls-health.com or Fax 1(660)-460-8110