# 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)

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☐ **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)

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**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:** _____

AFFINIA HEALTHCARE™

**Referral Line: 314-449-3553**
**Email completed form to MABReferral@affiniahealthcare.org**
**or Fax 314-814-8611**