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COVID-19 MONOCLONAL ANTIBODIES REFERRAL ORDER

Name: _____ DOB: _____ Date: _____

Allergies : _____ Date of suspected exposure or symptom onset: _____

Weight: _____ Height: _____ Patient Phone: _____

Diagnosis:

- ☐ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- ☐ U07.1 COVID-19 infection
- ☐ Other ICD: _____

Requirements:

- ☐ Over 18 yrs old or 12-17 yrs old weighing ≥ 88 lb.
- ☐ Patient on room with SPO2 >90% or if patient on regular flow rate of O2 if chronic O2 user. Patient cannot be requiring more O2 than normal. (Patient must bring their own O2.)

Check all applicable:

- ☐ 65 or older
- ☐ Chronic Kidney Disease
- ☐ Overweight/obesity (BMI>25)
- ☐ DM (I or II)
- ☐ Immunosuppressive Disease
- ☐ Other: _____
- ☐ Receiving Immunosuppressive Treatment
- ☐ Neurodevelopmental Disorder
- ☐ Pregnancy
- ☐ Cardiovascular disease
- ☐ Cardiomyopathy / CHF
- ☐ Cystic Fibrosis
- ☐ COPD, other chronic lung diseases
- ☐ Congenital Heart conditions
- ☐ History of CVA
- ☐ Asthma
- ☐ Current use or history of Smoking
- ☐ Medical-related technological dependence (trach, peg)
- ☐ Seizures
- ☐ Dementia
- ☐ Sickle Cell Disease
- ☐ Hypertension

☐ Positive COVID-19 Treatment

- ☐ Positive test within last 10 days (please attach results, photos NOT accepted)

☐ Pre-Exposure Prophylaxis

** For adults and children with certain high-risk, immunocompromised conditions. A physician will need to determine if whether Evusheld is an appropriate treatment.*

- ☐ Not currently infected with COVID-19
- ☐ **Option 1:** Moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments and may not mount an adequate immune response to the COVID vaccination
- ☐ No known recent exposure to SARS-CoV-2 infected individual.
- ☐ **Option 2:** For whom vaccination with any available COVID vaccine is not recommended due to history of severe adverse reaction to the vaccine or its components.

☐ Post-Exposure Prophylaxis

** As of July 31, 2021, FDA has issued EUA of Regen-Cov for adults and pediatrics 12 years of age and older for post-exposure prophylaxis of COVID-19 who are high risk of progression to severe COVID-19, including hospitilzation or death and are:*

- ☐ Not fully vaccinated or who are not expected to mount an adequate response such as those on immunosuppressive therapies.
- ☐ Has been exposed to SARS-CoV-2 infected individual in close contact per CDC criteria OR high risk of exposure to that individual due to institutionalized setting (nursing home, prison, etc.).

PLEASE ATTACH

- *Patient demographic information*
- *Positive SARS-CoV-2 testing*

FOR ALL HMO PLANS OR PLANS THAT HAVE AN ASSIGNED PCP:

- *A prior authorization will be needed from your insurance company for the infusion. Please attach the insurance authorization. Please contact us if current procedure codes are needed.*
- *Sorry, at this time we cannot do Medicaid, Cinga Medicare(Healthspring) or Texan Plus.*

FAX REQUEST FORM TO 409-527-3969.

WE WILL NOTIFY PATIENT AS SOON AS POSSIBLE TO GET INFUSION.

Date: _____ Physician Signature: _____