

gerstenberg.clinic

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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

Requirements:

- ☐ Over 18 yrs old or 12-17 yrs old weighing \geq 88 lb. ☐ Patient on room with SP02 >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:

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

☐ Positive COVID-19 Treatment

- ☐ Positive test within last 10 days (please attach)

☐ 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.*

- | | |
|--|--|
| <input type="checkbox"/> Not currently infected with COVID-19 | <input type="checkbox"/> No known recent exposure to SARS-CoV-2 infected individual. |
| <input type="checkbox"/> 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 | <input type="checkbox"/> 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 hospitalization or death and are:*

- | | |
|---|--|
| <input type="checkbox"/> Not fully vaccinated or who are not expected to mount an adequate response such as those on immunosuppressive therapies. | <input type="checkbox"/> 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, Cigna 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: _____