

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: _____
 Emergency Contact Name: _____ Cell Phone: _____

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 Onset of Illness (Mild to Moderate*) _____ = _____ **Day of Illness (<7)**

Date of Testing for COVID: _____ Test Type: PCR Antigen

- **Symptoms present less than 7 days:** Yes No/ : Not Eligible
- **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
- **Documented positive COVID test performed:** Yes No/ : Not Eligible

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)
- Obesity or being overweight (for example, BMI >25 kg/m²)
- Pregnancy
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension
- Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- Sickle cell disease
- Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation, not related to COVID-19)
- High risk Ethnicity Groups (Latino or Black)
- 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: Regeneron, Bamlanivimab + Etesevimab, Sotrovimab Prescription

Infusion Instructions for Available Monoclonal Antibody

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

Prescriber Name: _____ Date: _____

Prescriber Signature: _____

Email completed form to infusion@mynurx.com or fax to 956-382-6261

For Office Use Only:

County: _____ Pt Address: _____

Pt Email: _____ Pt Insurance: _____