UPDATED 5/24/2022

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: __________ Weight:_______

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

Patient Over 12 Years of age and Over 40kg	☐ **Yes**	☐ **No/ STOP : Not Eligible**	
Symptoms present less than 7 days:	☐ **Yes**	☐ **No/ STOP : Not Eligible**	
SpO2% greater than 90% on RA:	☐ **Yes**	☐ **No/ STOP : Not Eligible**	☐ **N/A**
If previously on home O2, has no increased need:	☐ **Yes**	☐ **No/ STOP : Not Eligible**	☐ **N/A**
Documented positive COVID test performed:	☐ **Yes**	☐ **No/ STOP : 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: ____