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)

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/ 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
- Stable for discharge home: ☐ Yes ☐ No/ STOP : Not Eligible ☐ N/A
- Documented positive COVID test performed: ☐ Yes ☐ No/ STOP : Not Eligible

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)
☐ 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, cysticfibrosis and pulmonary hypertension)
☐ Sickle cell disease
☐ Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic ormetabolic syndromes and severe congenital anomalies)
☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation, notrelated 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 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