COVID-19 Outpatient Monoclonal Antibody Infusion Referral Form

Fax Referral form to 870-793-1927

Patient:_____ DOB:_____

Patient phone number: _____ Last 4 digits of patient's SSN:_____

Section A: EUA mandatory requirements of the Provider (must meet all criteria)

Date of positive COVID-19 test:_____

Date of onset of symptoms _____(***must be within 7 days of symptom onset***)

Location of positive COVID-19 test:_____

_____ *(initial)* As the referring provider, I have reviewed the information contained within the "Fact Sheet for Patients and Caregivers" with the patient/caregiver. An electronic and/or hard copy of the "Fact Sheet for Patients and Caregivers" was given to the patient/caregiver.

_____(initial) As the referring provider, I attest that the patient does not require oxygen therapy due to COVID-19, OR does not require an increase in baseline oxygen flow rate due to COVID-19.

Section B: Patient Qualifiers

Patient must meet one of the following criteria (mark all that apply):

- ☐ Immunocompromised individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying conditions, regardless of vaccine status (*check immunocompromising condition below*)
  - ☐ Patients who are within 1 year of receiving B-cell depleting therapies (e.g., rituximab, ocrelizumab, ofatumumab, alemtuzumab)
  - ☐ Patients receiving Bruton tyrosine kinase inhibitors
  - ☐ Chimeric antigen receptor T cell recipients
  - ☐ Post-hematopoietic cell transplant recipients who have chronic graft versus host disease or who are taking immunosuppressive medications for another indication
  - ☐ Patients with hematologic malignancies who are on active therapy
  - ☐ Lung transplant recipients
  - ☐ Patients who are within 1 year of receiving a solid-organ transplant (other than lung transplant)
  - ☐ Solid-organ transplant recipients with recent treatment for acute rejection with T or B cell depleting agents
  - ☐ Patients with severe combined immunodeficiencies
  - ☐ Patients with untreated HIV who have a CD4 T lymphocyte cell count <50 cells/mm^3

Patient:_____ **DOB:**_____

- ☐ Unvaccinated individuals, 12 years of age and older, weighing at least 40kg, with one of the following risk factors (mark all that apply):
  - ☐ 65 years of age and older
  - ☐ Cancer
  - ☐ Cerebrovascular disease
  - ☐ Chronic kidney disease
  - ☐ Chronic lung disease (interstitial lung disease, pulmonary embolism, pulmonary hypertension, bronchopulmonary dysplasia, bronchiectasis, COPD, moderate to severe asthma, cystic fibrosis)
  - ☐ Chronic liver disease (cirrhosis, non-alcoholic fatty liver disease, alcoholic liver disease, autoimmune hepatitis)
  - ☐ Dementia or other neurological conditions
  - ☐ Diabetes mellitus (type 1 and type 2)
  - ☐ Down Syndrome
  - ☐ Heart conditions (heart failure, coronary artery disease, congenital heart disease, or cardiomyopathies)
  - ☐ HIV infection
  - ☐ Mental health disorders (mood disorders [including depression], schizophrenia spectrum disorders)
  - ☐ Obesity (body mass index ≥30 kg/m^2)
  - ☐ If 12 to 17 years of age, have BMI ≥85th percentile for their age and gender based on CDC growth charts
  - ☐ Sickle cell disease or thalassemia
  - ☐ Smoking, current and former
  - ☐ Tuberculosis
  - ☐ Non-white race OR Hispanic/Latino ethnicity
  - ☐ 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]

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If vaccinated, has patient received a booster?

- ☐ Yes
- ☐ No

***Contraindications for Paxlovid:**

_____

_____

By signing below, I attest that the patient meets the emergency use authorization (EUA) for the monoclonal antibody infusion and the information on this form is accurate to the best of my knowledge.

Date:_____ Signature:_____

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