PRESBYTERIAN
Infusion Services

Provider Referral
COVID-19 Monoclonal Antibody Therapy

Patient
Name (Last, First): _____

DOB: _____ Age:____ Primary Language:_____

Provider
Name (Last, First): _____

Phone: _____ Referral Help Line: (505) 291-2626

Bamlanivimab and Casirivimab/Imdevimab Eligibility

Bamlanivimab and Casirivimab/Imdevimab are unapproved monoclonal antibody therapies under FDA Emergency Use Authorization for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older; weighing at least 40 kg; and, who are at ***high risk*** for progressing to severe COVID-19 and/or hospitalization.

Monoclonal antibodies should be administered as soon as possible after positive SARS-CoV-2 (PCR or antigen testing) and ***within 10 days of symptom onset.*** Patients are not eligible for treatment if > 10 days from symptom onset. Not all Infusion Centers are able to facilitate pediatric infusions; please call your local site to confirm.

Per FDA requirements, patients will be provided an FDA *Fact Sheet for Patients, Parents and Caregivers* prior to infusion therapy.

Patient Eligibility: Patient **must meet at least one High Risk criterion** for treatment eligibility. Check all that apply.

- ☐ Body mass index (BMI) ≥ 35
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease
- ☐ Currently receiving immunosuppressive treatment
- ☐ ≥ 65 years of age
- ☐ ≥ 55 years of age **AND** have at least one of the following. Check all that apply.
  - ❍ Cardiovascular disease
  - ❍ Hypertension
  - ❍ Chronic obstructive pulmonary disease/other chronic respiratory disease
- ☐ 12-17 years of age **AND** have at least one of the following. Check all that apply.
  - ❍ BMI ≥ 85th percentile for age and gender based on CDC growth charts
  - ❍ Sickle cell disease
  - ❍ Congenital or acquired heart disease
  - ❍ Neurodevelopmental disorders, for example cerebral palsy
  - ❍ A medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
  - ❍ Asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

Required Patient Referral Information*

Date of Symptom(s) Onset:		1st COVID-19 Positive Test Result Date in past 90 days:			
Covid-19 Testing Location:		City:		State:	
*Include in the fax patient demographic information from the patient health record that includes a copy of their complete insurance data.					

Referring Provider Information

Provider Name:		Provider Phone Number:			
Primary Practice Address:		City:		State:	

Therapy Location

Please schedule patient for treatment at one of the following Presbyterian Infusion Centers:

◯ Albuquerque ◯ Santa Fe ◯ Ruidoso ◯ Clovis ◯ Socorro ◯ Tucumcari ◯ Espanola

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Provider Attestation

☐ I attest the patient I am referring for Bamlanivimab (700 mg IV) or Casirivimab/Imdevimab (1200 mg/1200 mg IV) therapy:

- has a recent positive SARS-CoV-2 test result,
- is under my medical care and will follow up with me for any necessary COVID-19- related medical issues,
- has become symptomatic in the past 10 days (and can reasonably be scheduled for treatment within 10 days of symptom onset),
- is ≥ 12 years of age,
- weighs ≥ 40 kg,
- has been informed (or parents/caregivers have been informed) of alternatives to receiving this medication,
- has been informed (or parents/caregivers have been informed) that the medication is an unapproved product permitted for use under an Emergency Use Authorization only,
- has been advised (or parents/caregivers have been advised) to report any suspected adverse drug events to this Infusion Center immediately for FDA reporting,
- may receive either Bamlanivimab or Casirivimab/Imdevimab, depending on drug availability, as the indications and restrictions are similar for both therapies, and
- does NOT meet ANY of the following exclusionary criteria:
  - previously hospitalized due to COVID-19, OR
  - requires oxygen therapy due to COVID-19, OR
  - requires an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related co-morbidity

Provider Signature: _____ **Date:** _____

(Signature stamps not accepted, wet signature required)

Referral Submission Instructions

Please fax all the of the following, in one fax, to the Presbyterian Infusion Center Fax (505) 355-7158.

☐ Fax coversheet from referring provider primary practice

☐ This Presbyterian Infusion Center Referral Form, fully complete, including wet signature of provider

☐ Patient Demographics (Patient Name, DOB, Address, Insurance, Primary Language)

☐ Copy of most recent clinical encounter (e.g. History and Physical, Progress Note, Telephone Note, Video Visit)

☐ Copy of positive COVID-19 test result.

Test result may be sent from provider's office OR patient may present hard copy, text, or email of positive test result for verification at time of appointment.

PLEASE NOTE: treatment will not be provided unless positive COVID-19 test result is confirmed.

Referral Provider Comments