OH REFERRAL FOR APPROVED MONOCLONAL ANTIBODY

(OHRH will use casirivimab/imdevimab (REGEN-COV), bamlanivimab/etesevimab, OR Sotrovimab based on availability and state recommendations)

Patient Name: _____ Patient's Age _____

Patient's DOB: _____ Patient's Contact Number: _____

***All Questions Must be Answered before Order is Valid* Fax Completed Form to 270-688-2275**

Has patient had a positive Covid-19 test in the past ten (10) days? Yes or No

For patients with mild to moderate Covid-19 symptoms and (Yes) to Positive Covid-19 test what date did the test occur? _____.

Date of symptom onset? _____

If patient has any of the following contraindications then monoclonal antibodies isn't a treatment option.

- Less than 12 years of age
- Weight under eighty-eight pounds
- Require oxygen therapy due to Covid-19
- Require an increase in baseline oxygen flow rate due to Covid-19 in those on chronic oxygen therapy

Indications for use: (Check all that apply)

References: Statement on Patient Prioritization for Outpatient Therapies
COVID-19 Vaccines for Moderately or Severely Immunocompromised People

☐ **Immunocompromised patient regardless of vaccination status**
Criteria for moderate or severe immunocompromised listed below (check all that apply):
- ☐ Been receiving active cancer treatment for tumors or cancers of the blood
- ☐ Received an organ transplant and are taking medicine to suppress the immune system
- ☐ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- ☐ Moderate severe primary immunodeficiency (such as DiGeorge Syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids or other drugs that may suppress the immune system

☐ **Age ≥ 75 years regardless of vaccination status**

☐ **Age ≥ 65 years AND unvaccinated OR > 6 months since last vaccine (have not received booster), and at least one risk factor below (check all that apply)**
- ☐ BMI ≥ 25
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Hypertension or cardiovascular disease (including congenital heart disease)
- ☐ Chronic lung disease (i.e. COPD, moderate/severe asthma, interstitial lung disease, CF, pulmonary HTN)

☐ Pregnant patient regardless of vaccination status

Has the Patient and/or Caregiver received "Fact Sheet" information in written or verbal form? Yes or No

Has Patient been informed of alternatives to receiving a monoclonal antibody? Yes or No

Has the Patient been informed that monoclonal antibodies are an unapproved drug that is authorized for use under the Emergency Use Authorization? Yes or No

Provider Printed Name: _____

Provider Signature: _____

By signing above you are authorizing the patient to receive either casirivimab/imdevimab, bamlanivimab/etesevimab or Sotrovimab based on availability and indications.