OH REFERRAL FOR APPROVED MONOCLONAL ANTIBODY

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

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? _____.

If positive test, has it been identified as the Omnicron variant? Yes or No (If yes, the patient will be administered Sotrovimab if available.)

Date of symptom onset? _____

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

- 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.

<u>Indications for use: (Check all that apply. Italicized indications could make the patient eligible for Sotrovimab if available. Otherwise alternative monoclonal antibody will be administered.)</u>

- ☐ *Age ≥ 65 years*
- ☐ Obesity or overweight (BMI > 25 or, for 12-17 years of age, BMI > 85th percentile for age and gender based on CVC growth charts https://www.cdc.gov/growthcharts/clinical_charts.htm)
- ☐ *BMI > 35-40*
- ☐ *Pregnant*
- ☐ *Chronic kidney disease*
- ☐ Diabetes
- ☐ *Diabetes (poorly controlled)*
- ☐ *Immunosuppressive disease or immunosuppressive treatment*
- ☐ *Stroke*
- ☐ *Hypertension or cardiovascular disease (including congenital heart disease)*
- ☐ *Chronic lung disease (i.e. COPD, moderate/severe asthma, interstitial lung disease, CF, pulmonary HTN)*
- ☐ Sickle cell disease
- ☐ Neurodevelopmental disorders (i.e. CP) or other conditions that confer medical complexity (i.e. genetic or metabolic syndromes and severe congenital abnormalities)
- ☐ Medical-related technological dependence (i.e. tracheostomy, gastrostomy, or positive-pressure ventilation not related to COVID-19)
- ☐ *Two or more risk factors*

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.