Phone: 616-954-0600 Fax: 616-818-4484

Monoclonal antibody treatment for COVID-19 IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10: _____, _____, _____

*****Therapy is not indicated in patients that are less than 12 years old, less than 40 kgs, require oxygen therapy due to COVID-19, or require an increase in baseline oxygen flow rate due to COVID-19*****

Date of symptom onset:_____

Date of positive SAR-CoV-2 test result:_____ ****ATTACH RESULTS****

Patient qualifies for treatment under the EUA due to:_____

☐ Casirivimab 600mg IV + Imdevimab 600mg IV x1

Patient may qualify for a clinical trial in which additional therapy is offered.

If my patient qualifies, I would like him/her to have the option to take advantage of this opportunity ☐Yes ☐ No

I would like more information on the clinical trial. Please have a research staff member reach out to me to discuss further ☐Yes ☐ No

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____