Infusion ASSOCIATES

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

Monoclonal antibody treatment for COVID-19

*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: ☐ **U07.1 Confirmed COVID-19**
☐ **Z20.822 Contact with and (suspected) exposure to COVID-19**

*****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:_____ *[to qualify patient must be w/in 10 days of symptom onset]*

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

Is patient fully vaccinated? ☐ **YES** ☐ **NO**

Patient qualifies for treatment under the EUA as high risk for progression to severe disease due to:

☐ Age 65 years or older
☐ BMI >25kg/m2
☐ Pregnancy
☐ CKD
☐ Diabetes
☐ Chronic lung disease
☐ Immunosuppressive disease or treatment
☐ Cardiovascular disease or hypertension
☐ Sickle cell disease
☐ Medical-related technological dependence not related to COVID-19
☐ Neurodevelopmental disorder or other medically complex condition
☐ Other: _____

Pharmacist to select product based on availability:

Casirivimab 600mg IV + Imdevimab 600mg IV or SQ x1
OR
Bamlanivimab 700mg IV + Etesevimab 1400mg IV x1
OR
Sotrovimab 500 mg IV x 1

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:** _____