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**

*****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 within **7days** of symptom onset]*

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

Is patient fully vaccinated plus booster if applicable? ☐ **YES** ☐ **NO**

Priority risk factors:
☐ BMI >25kg/m2
☐ Immunosuppressive disease or on immunosuppressive treatment
☐ Sickle cell disease
☐ Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
☐ Chronic respiratory disease (CF, ILD, COPD or asthma requiring daily inhaled corticosteroids)
☐ Pregnancy
☐ CKD
☐ Cardiovascular disease (CVA, valvular disease, PAD, CHF, HTN)
☐ Diabetes

Bebtelovimab 175 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:** ____________________________