COVID Monoclonal Antibody Referral Form

Patient Name: _____ Date of Symptom Onset: _____

Patient DOB: _____ Date of Test Administration: _____

Patient's Phone Number: _____ Date of Positive Result: _____

Please mark the indication for MAB Infusion (At least one of the following):

◯ Body Mass Index ≥35

◯ Diabetes

◯ Chronic Kidney Disease

◯ Immunosuppressive Disease

◯ Currently Receiving Immunosuppressive Therapy

◯ Age ≥ 65 years of age

◯ ≥55 years of age and have: cardiovascular disease, OR hypertension, OR chronic obstructive pulmonary disease/other chronic respiratory disease

◯ Age 12-17 years of age AND have: BMI >85th percentile for their age and based on CDC growth charts, OR sickle cell disease, OR congenital or acquired heart disease, OR neurodevelopmental disorders, OR a medical-related technological dependence or positive pressure ventilation (not related to COVD-19), OR asthma, reactive airway or chronic respiratory disease requiring daily medications. Weight must be greater than 40 kg.

Referring Physician: _____ Phone Number: _____

Signature: _____ Today's Date: _____

Note: Please fax this form AND a copy of the patient's test result with their name and the date of the test to **(907) 349-1920**. The office will then contact the patient at the provided number if they can be scheduled for an infusion. Thus, it is imperative that the best contact number be provided.

----------For Administrative Use Below This Line----------

Patient Given the "Fact Sheet for Patients, Parents and Caregivers". Informed of alternatives to receiving authorized bamlanivimab and informed that bamlanivimab is an unapproved drug that is authorized for use under this EUA. Signature: _____

Adverse Drug Reaction (details): _____

30 Day Follow up: Hospitalized: _____Outcome: _____

Last Day Eligible for infusion and Notes: