Charleston Area Medical Center

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COVID-19 MONOCLONAL ANTIBODY THERAPY

PLEASE RETURN THIS FORM AND CAMC COVID-19 Monoclonal Antibody Infusion Order TO EMAIL: AMB.IRC@CAMC.ORG FAX: 304-388-8527

PATIENT INFORMATION:

First Name: _____ M.I._____ Last Name: _____

D.O.B.: _____ SSN: (Last 4 digits)_____ Marital Status: ❑S ❑M ❑W ❑Sep Sex: ❑M ❑F

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone: (_____) _____ Work Phone: (_____) _____

GUARDIAN / GUARANTOR: *(IF UNDER 18* must be accompanied by guardian to infusion)

Name: _____ Birthdate: ____/_____/_____ Relationship: _____

PROVIDER INFORMATION: ❑DO ❑NP

Requesting Provider: _____ ❑MD ❑PA **NPI #:**_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____ Contact Person: _____

INSURANCE INFORMATION: *[Please include a copy of the card(s)]*

Insurance Carrier: _____ **Policy #:** _____

Authorization #: _____Valid through: _____ How many visits: _____

Please attach a facesheet and copy of COVID PCR or Antigen Results.

Please return form with positive test results.

APPOINTMENT DATE: _____ ***(Day and Date)***

TIME: _____ ❑ **AM** ❑ **PM**

DATE: _____ **TIME:** _____ **SIGNATURE:** _____

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CRITERIA and ORDER for COVID -19 MONOCLONAL ANTIBODY INFUSION at CAMC

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Patient Name: **DOB:**

Monoclonal antibody therapy should be reserved for patients at high risk for progressing to severe COVID-19 and/or hospitalization per criteria defined in the EUA as listed below. Utilization will be monitored and adjustments made to these criteria as resources change or as state / regulatory agencies deem appropriate.

COVID Positive adult and pediatric individuals who meet the criteria for high risk of progressing to severe COVID-19

Infusion is administered as soon as possible after a positive viral test for SARS-CoV-2 and within 10 days of symptom onset.

Date of Onset of Symptoms _____

Patient Date of Birth _____ Patient Age _____

Vaccination Status 1 Dose ☐ Manufacturer_____Date_____

2 Doses ☐ Manufacturer_____Date_____

Booster ☐ Manufacturer_____Date_____

May NOT have any of the following:

Exclusion Criteria:

1. Patients hospitalized due to COVID-19
2. Patients requiring oxygen due to COVID-19 or an increase from baseline
3. Greater than 10 days of symptoms
4. Less than 12 years old
5. Less than 40 kg

Need ONE of the following:

(Please check the appropriate criteria)

Inclusion Criteria (individuals at high risk for severe progression of COVID -19):

- ☐ Older age (≥65 years of age)
- ☐ Obesity or being overweight (adults with BMI >25 kg/m2, or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts
  Pt Weight _____ Pt Height _____
- ☐ Pregnancy
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease or immunosuppressive treatment
  - ○ Active Cancer
  - ○ Transplant patient
  - ○ Immunosuppressive medication: _____
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- ☐ 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)

☐ casirivimab/imdevimab 1200 mg IV piggyback once, infuse over 20 minutes.

Per CAMC approved therapeutic interchange, patient may receive bamlanivimab 700 mg/etesevimab 1400 mg IV piggyback once, infuse over 40 minutes or sotrovimab 500 mg IV piggyback once, infuse over 30 minutes.

I attest that at the time of ordering, the patient meets the above-mentioned criteria for use under the EUA for Casirivimab / Imdevimab OR Bamlanivimab/Etesevimab OR sotrovimab

DATE: **TIME:** **PHYSICIAN SIGNATURE:**