Maryland Referral Form for Ambulatory Monoclonal Antibody Infusion Treatment for COVID19

Please complete this form in its entirety answering and including as much patient information as you can. The (**) indicates a required field. *Submit this form to the site closest to the patient. The Infusion Site team will review the referral form upon receipt and contact the patient to coordinate services as soon as possible. Please do not call or request preferential treatment as the team will triage and work to meet the needs of the patient with the limited dosing available. Thank you for your understanding.*

Region 1: UPMC Western Maryland Hospital (Cumberland)	*Email form to WMD-COVIDantibody@upmc.edu*
Region 2: Meritus Regional Infusion Center (Hagerstown)	*Fax form to 301-790-9229*
Region 3: Baltimore Convention Center Field Hospital	*Go to umms.org/ICReferral to submit form via secure, HIPAA-compliant upload.*
Region 4: TidalHealth Peninsula Regional (Salisbury)	*Email form to* COVIDTX@TidalHealth.org or *Fax: 410-912-4959*
Region 5: Adventist HealthCare Takoma Park Alternative Care Site Infusion Center	*Fax form to 301-891-6120*

**First Name:

**Last Name:

**DOB:

Age:

**Sex: ☐ M ☐ F ☐ Other _____ ☐ Unknown

**Patient's Preferred Language ☐ English ☐ Spanish ☐ Other _____

**Address Line 1:
Address Line 2:

City:
State:
County:

**Zip:

**Phone:
☐ cell ☐ home

Secondary Phone:
☐ cell ☐ home

Emergency Contact Name:

Emergency Contact Relationship:

Emergency Contact Phone:
□ cell □ home

Allergies (medication/food/other):

Please include any additional information re: patient's health history and medication history. You may free text, copy/paste, or you may attach a recent clinic note or other document that includes current problem list, health history (major surgeries, major illnesses), current medication list, and medication allergies.

Inclusion and Exclusion Criteria:

**Weight (lbs): Kg:

**Height (feet/inches):

BMI:

**Patient has had a recent SARS-CoV2 PCR Positive Test Result: □ Yes □ No
(Test must be first known positive test result.)

**SARS-CoV2 PCR test date (date specimen was obtained): _____

****SARS-CoV2 symptom onset date (best approximation)**: _____
[Note: monoclonal antibody treatment is approved for patients with mild to moderate COVID symptoms. Asymptomatic patients likely will not benefit and should not be referred.]

**Patient Symptoms (check all that apply):
□fever □cough □SOB □loss of taste/smell □malaise/fatigue
□ Nausea/Vomiting □Diarrhea □Throat pain □Congestion □Myalgia
□ Headache □Other _____

**SpO2: ____ (If < 94%, patient should be referred for hospitalization due to need for supplemental O2 and thus would not be appropriate for monoclonal antibody treatment.)

□ On RA or □ On chronic O2 therapy – Baseline O2 Flow rate: _____

Has the patient required an increase in O2 flow rate since becoming symptomatic with COVID? □ Yes □ No

High Risk for Severe COVID Illness (check all that apply):

□ Age ≥ 65 y/o
□ BMI ≥ 35
□ CKD Disease Stage ____ Baseline [Cr]____
□ Diabetes Mellitus [□ Type II □Type I
□ Immunosuppressive Disease (e.g. leukemia, lymphoma, asplenia, neutropenia, AIDS if CD4 < 200, etc.) / Specify: _____
□ Immunosuppressive Treatment (e.g. chronic steroid, chemotherapeutic, biologic immunomodulator) / Specify: _____

□ Age ≥ 55 y/o *and:*
□ Cardiovascular Disease / Specify (e.g. CAD, CVD, PVD, cardiomyopathy): _____
□ HTN
□ COPD
□ Other Chronic Respiratory Disease (e.g. Pulmonary Sarcoid, Pulmonary Fibrosis) / Specify: _____

□ Age 12 – 17 y/o *and:*
□ BMI ≥85th percentile for their age and gender based on CDC growth charts https://www.cdc.gov/growthcharts/clinical_charts.htm
□ Sickle Cell Disease
□ Congenital or acquired heart disease / Specify: _____
□ Neurodevelopmental Disorder (e.g. cerebral palsy, muscular dystrophy) / Specify: _____
□ Medical-related technological dependence (e.g. trach, g-tube dependence, shunt dependence, chronic infusion dependence) / Specify: _____
□ Asthma/Reactive Airway Disease/Chronic Respiratory Disease Requiring daily medication for control / Specify: _____

I, the referring provider, am the patient's PCP or other continuity provider and have arranged for the patient to follow up with me/my designee following Antibody infusion. Or I am an ED or Urgent Care provider who will update the patient's PCP about his/her Antibody infusion in order to arrange follow up. If the patient does not have a PCP, I will refer him/her to an appropriate provider and ensure that follow up has been arranged. [Note: Ideal timing of follow up visit is approximately 7 days post-infusion.]
****□ Indicates Provider Agreement**

I, the referring provider, have advised or will advise the patient that if his/her clinical status declines by the time of the infusion appointment, the treatment may no longer be appropriate for him/her. The patient's clinical status will be re-evaluated at the infusion center at the appointment time. If the patient is deemed in need of hospital care, s/he will be referred immediately.
****□ Indicates Provider Agreement**

The Infusion Center staff will communicate with the referring provider regarding such matters as treatment inappropriateness for patient, ultimate completion of treatment for patient, adverse events, etc.

Name of Referring Site:
Address:
Point of Contact:
Phone Number:
Fax Number:
Email address:
Preferred mode of contact: ☐ Phone ☐ Fax ☐ Email

Patient's Primary/Continuity Care Provider (if different from above)
Office Name:
Address:
Phone Number:
Fax Number:
Email address:

There are two Antibody treatments on our formulary. Patients will be scheduled for one or the other treatment based on availability of medications and logistics.

Information about both medications, Casirivimab+Imdevimab or *Bamlanivimab, including Fact Sheets and Manufacturer Instructions/Package Inserts for Healthcare Providers and for Patients/Parents/Care Givers, can be found at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs (scroll to section on Drugs and Biologic Products).*

Office-Use Only

☐ **Patient Qualifies for Antibody Therapy**
__ SARS-CoV-2 **Positive** by PCR
__ Within Treatment Window (< 10 days since symptom onset)
__ Qualifying Secondary Diagnosis:
__ Patient is not exhibiting need for new or increased O2 therapy

** Antibody treatment window for patient this will terminate on _____ (date will auto-populate)

☐ **Patient Does Not Qualify for Antibody Therapy**
__ Patient is outside of treatment window; treatment window ended on _____
__Patient requires hospitalization due to a new or increased O2 need
__Patient does not have a secondary qualifying diagnosis
__Patient's weight < 40 Kg