



Maryland Referral Form
Ambulatory Monoclonal Antibody Infusion Treatment for COVID-19

Please complete the information on this form if your patient could benefit from monoclonal antibody treatment. This form should be sent to the infusion site with closest proximity to the patient.

Please note: CRISP eReferral is the quickest way to conduct a referral. This form is for providers without access to the portal to submit as indicated on page 4.

****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:** _____

County: _____

****Phone:** _____ • cell • home **Secondary Phone:** _____ • cell • home

Allergies (medication/food/other. Please include any additional historical patient health information. You may free text or attach a recent clinic note or other documentation as necessary):

****Vaccination Status:**

Patient Eligibility

For COVID-19 Treatment: Bebtelovimab

Monoclonal antibodies directed against SARS-CoV-2 may be used in adults ages 12 and older who are at high risk for progressing to severe COVID-19 and/or hospitalization. Patients are considered at high risk if they meet any one of the following criteria:

- o Older age (e.g., age ≥ 65 years of age)
- o Obesity or being overweight (e.g., adults with BMI >25 kg/m², or if age 12-17, have BMI ≥ 85 th percentile for their age and gender based on CDC growth charts (https://www.cdc.gov/growthcharts/clinical_charts.htm))
- o Pregnant
- o Chronic kidney disease
- o Diabetes
- o Immunosuppressive disease or immunosuppressive treatment

The (**) indicates a required field.

- o Cardiovascular disease (including congenital heart disease) or hypertension
- o Chronic lung diseases (e.g., chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis, and pulmonary hypertension)
- o Sickle cell disease
- o Neurodevelopmental disorders (e.g., cerebral palsy) or other conditions that confer medical complexity (e.g. genetic or metabolic syndromes and severe congenital anomalies)
- o Having a medical-related technological dependence [e.g., tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)]
- o Having medical conditions and factors associated with increased risk for progression to severe COVID-19

Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19 and authorization of REGEN-COV under the EUA is not limited to the medical conditions or factors listed above. For additional information on medical conditions and factors associated with increased risk for progression to severe COVID, see the CDC website:

<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>. Healthcare providers should consider the benefit-risk for an individual patient.

Individual area health systems may have further inclusion and exclusion criteria.

Indications:

- Treatment of mild to moderate COVID-19 in adult and pediatric patients with positive results of direct SARS-CoV-2 viral testing in accordance with EUA criteria for dosing, administration and patient eligibility

Date of positive COVID-19 test _____ **Date of symptom onset** _____

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 monoclonal antibody infusion. Or I am an ED or Urgent Care provider who will update the patient’s PCP about his/her antibody infusion 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**

**** Please provide the following information:**

- If a patient meets the above criteria, give available EUA-approved monoclonal antibody treatment as appropriate according to the EUA dosage and administration instructions per protocol.

*The (**) indicates a required field.*

Information about both monoclonal antibody treatment can be found at [FDA Emergency Use Authorization Drug and Biological Products, COVID19 Therapeutics](#) (scroll to section on Drugs and Biologic Products).

Provider Signature _____

Date _____

The monoclonal infusion 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:

Point of Contact:

Address:

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:

Email address:

Fax Number:

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Table 1. How to Refer a Patient		
Allegany County	UPMC Western Maryland	Email form to WMD-COVIDantibody@upmc.edu
Baltimore City	Hatzalah of Baltimore	Submit to Hatzalah Infusion Center Referral Form via secure link or email to covidtherapy@hatzalahbaltimore.org
Baltimore City	BCCFH State Center: Infusion Site *No cost to patients	Submit a form via secure, HIPAA-compliant upload.
Baltimore County	Nasseri Clinics of Arthritic Rheumatic Diseases	Fax referral form 410-744-8036
Calvert County	CalvertHealth Outpatient COVID Treatment Clinic	Email referral to COVIDtx@calverthealthmed.org
Cecil County	ChristianaCare Union Hospital	Fax referral form to 410-392-2637
Central Maryland (home infusion in multiple counties)	American Infusion Services	Fill out HIPAA-compliant form
Charles County	Charles Regional Medical Center	Submit a form via secure, HIPAA-compliant upload.
Hartford County	UM Upper Chesapeake Infusion Center	Submit a form via secure, HIPAA-compliant upload.
Montgomery County	Adventist Takoma Park	Fax form to 301-891-6120
Washington County	Meritus Medical Center	Refer via site-specific referral form
Wicomico County	TidalHealth	Fill out referral form
<p><u>Patient must verify exact address with scheduling department.</u></p> <p><i>*Certain sites also accept direct patient contact to determine eligibility and schedule treatment</i></p> <ul style="list-style-type: none"> ● <i>Baltimore City Convention Center Field Hospital Infusion Center-- Call 410-649-6122 or complete a self-referral form *No cost to patients</i> ● <i>American Infusion Services– AmericanInfusion.com and 1-855-AM-INFUS (home infusion)</i> ● <i>Hatzalah of Baltimore-- Self-referral form or call 410-585-0054</i> ● <i>MedStar eVisit offers virtual appointments to meet with a provider</i> <p>**Home Infusion may be an available option for UMMS patient referrals on Mon-Fri 8 am – 5 pm through UM Medical Solutions. Fax: 410-636-0309</p>		

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