COVID-19 Monoclonal Antibody (mAb) EUA Treatment Referral

(For use by non-Houston Methodist Provider)

[redacted]

Patient Name:	Date of Birth
Patient Contact Information: Home: Mobile:	
Allergies:	Height / Weight

Note: Indication for COVID-19 mAb per EUA criteria: Treatment of mild to moderate COVID19 disease in adults with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older, weigh at least 40 kg, and are at ***high risk*** of progressing to severe COVID-19 and/or hospitalization. Bam* EUA Criteria / Casi/Imd* EUA Criteria **HM treats adult patients only. HM will not accept referrals for patients less than 18 years old.**

Dr. Huang: I have assessed the patient and provide the following relevant clinical information:

Date patient's symptoms started _____/_____ *Per EUA criteria treatment must be given within 10 days of symptom onset. To allow time for review & scheduling, HM accepts ambulatory referrals only if patients are within 6 days of symptom onset.

Date of positive COVID-19 test: _____/_____ **Type of COVID test performed:** (PCR) (Antigen)

Treatment-qualifying High-Risk Condition(s) Present: (must have one of these)

☐ BMI greater than or equal to 35 ☐ Chronic kidney disease ☐ Diabetes ☐ Immunosuppressive disease or treatment

☐ Greater than or equal to 65 years of age

OR:

☐ Greater than or equal to 55 YO **AND has**: ☐ Cardiovascular disease, OR ☐ Hypertension, OR ☐ COPD/chronic resp. disease

NOTE: EUA approved COVID-19 mAb are NOT authorized for use in patients hospitalized due to COVID-19, OR who require oxygen therapy due to COVID-19, OR who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

NOTE: Regarding Covid-19 vaccination status and mAb use: While not prohibited by CDC Guidance, mAb use 14 or more days after initial Covid vaccination may not be beneficial. Patients receiving mAb therapy should defer initial or booster vaccinations for at least 90 days after mAb administration

☐ I affirm that my patient meets above criteria for use and has been:

a. Given the COVID-19 mAb (Bamlanivimab or Casirivimab/Imdevimab) "Fact Sheet for Patients, Parents and Caregivers"
b. Informed of alternatives to receiving authorized COVID-19 mAb (bamlanivimab OR casirivimab/imdevimab)
c. Informed that (bamlanivimab OR casirivimab/imdevimab) is an unapproved drug that is authorized for use under an EUA

☐ I am aware:

a. That my patient may receive either bamlanivimab 700 mg in sodium chloride 0.9% 270 mL, **OR** casirivimab and imdevimab 1,200mg/1,200mg in sodium chloride 0.9% 250 mL (Selection based on product availability)
b. That infusions are administered over 1 hour and the patient will be monitored in the infusion clinic for 1 hour post infusion
c. That hospital standard hypersensitivity reaction therapy will be provided as needed

Scan and email to: COVID19MAB@houstonmethodist.org **OR** Fax to: 346-356-1196

Physician's Name (Print)	Physician's Direct Contact Number (not the office line)
Physician's Signature	Date/Time

PATIENT LABEL

HOUSTON Methodist LEADING MEDICINE

Form # 290-1 (revised 1/8/2021)