MONOCLONAL ANTIBODY REFERRAL FORM

AMBER™ SPECIALTY PHARMACY

PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Social Security #	Primary Language
Address		
City	State	ZIP
Allergies		
Phone	Height	Weight
Symptom Onset Date	COVID Positive Date	

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		Referral Contact Email
Office Phone		Office Fax
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		
Prescriber NPI		

INSURANCE INFORMATION

Insurance Provider	Plan ID #
Insured's Name	Relationship to Patient

Eligible for Medicare (check one) ☐ Yes ☐ No — List Red, White & Blue Card #

If no insurance, list driver's license number and state of issue

Please fax with order form: Current Medication List & Copy of Insurance Card

ELIGIBILITY

Exclusion Criteria: If patient meets any of the following, they are not eligible for treatment:

- Hospitalized due to COVID-19
- Require oxygen therapy due to COVID-19
- Require an increase in baseline oxygen flow due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

Inclusion Criteria: Patients must be >=12 years old (Age:), AND weigh >=40kg (Wt kg), AND be at high risk for progressing to severe COVID-19 or hospitalization.

• Factors which place this patient at higher risk (check all that apply) •

- ☐ Older age (i.e. >= 65 Years old)
- ☐ Overweight/obese (i.e. BMI>25, or pediatrics >85th%)
- ☐ Pregnancy
- ☐ Chronic Kidney Disease
- ☐ Diabetes
- ☐ Immunosuppressive Disease or Treatment
- ☐ Chronic Lung Disease
- ☐ Sickle Cell Disease
- ☐ Cardiovascular Disease or Hypertension
- ☐ Medical-related Technological Dependence
- ☐ Other (please specify)

MEDICATION ORDERS

*Pharmacist to choose brand based on availability. **If you prefer to prescribe one of the options, please cross out the brand you do not want to prescribe** (this may cause a treatment delay).

- ☒ ***Casirivimab and Imdevimab (REGEN-COV):** 600 mg / 600 mg IV x 1 dose Directions: Infuse IV over 30 minutes per manufacturer guidelines.
- ☒ ***Bamlanivimab and Etesevimab:** 700 mg / 1.4 gm IV x 1 dose Directions: Infuse IV over 30 minutes per manufacturer guidelines.
- ☒ ***Sotrovimab:** 500mg: Directions: Infuse IV over 30 minutes per manufacturer guidelines.
- ☒ **50ml Sodium Chloride** 0.9% Once infusion complete, flush the line with 50ml 0.9% Sodium Chloride.
- ☒ **Flush line with D5W**, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Amber Specialty Pharmacy protocol.
- ☒ **Anaphylaxis Kit** per Amber Specialty Pharmacy Home Infusion anaphylaxis treatment protocol.

Indicate IV access type:

Prophylaxis: Dose: Route:

Nursing Orders

- RN to insert peripheral IV or access existing central catheter.
- RN to observe patient for 1 hour post-infusion.
- RN to complete patient assessment.

SIGNATURE

Prescriber Signature _____ Date _____

Please Print Name _____ NPI _____

Phone: 855.896.9254
Fax: 855.370.0086