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 and Time of Day	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		

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 (for example tracheostomy, gastrostomy, or positive pressure ventilation (unrelated to COVID-19))
- ☐ Neurodevelopmental disorders (e.g. cerebal palsy) or other conditions that confer medical complexity (e.g. genetic or metabolic syndromes and severe congenital anomalies)
- ☐ Other (please specify)

MEDICATION ORDERS

***Due to the high prevalence of the Omicron variant, Sotrovimab is the current MAB of choice for COVID-19 Therapy.** REGEN-COV and Bam/Ete are available but can only be dispensed per prescriber request. The patient must be notified by prescriber prior to infusion of the potential of Bam/Ete or REGEN-COV therapy to be less than effective.

- ☐ ***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:

Indicate vaccination status:

☐ Unvaccinated ☐ Partially Vaccinated ☐ Fully Vaccinated ☐ Boosted

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

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