# 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

- ☒ ***Bebtelovimab:** 175mg/2ml IVP: Directions: Must be given in 7 days from onset of symptoms.
- ☒ **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:**

Peripheral: PICC: Port:

**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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