



**COVID-19 Monoclonal Antibody - EUA Use
Provider Referral Form**

Complete and Fax to Cornerstone team: 570-794-6124
Phone number: 570-573-3318 or 570-794-6123

Patient Information:

Name _____ Date of Birth ____/____/____

Address (or Facility Information):

Facility Name _____ Room Number _____

Address _____

City _____ State _____ Zip code _____

Contact Person related to this order: _____ Phone/extension: _____

Sex: M F Weight _____ kg Height _____ cm

Drug Allergies: _____

TREATMENT

Please send patient medical history, medication list, Advanced Directives and Insurance information

Diagnosis: COVID-19 (U07.1)

Date of positive COVID-19 test: _____ (Send positive test results with order form)

Date of symptom onset: _____

Current Symptoms: _____

OR

PROPHYLAXIS

Comments:

Exclusions for Therapy:

- Symptoms of COVID >10 days
- Hospitalized due to COVID-19
- NEW Requirement for Oxygen therapy due to COVID-19
- Increased oxygen flow rate requirement due to COVID-19 when previously on oxygen therapy
- **People who likely mounted a protective immune response after vaccination**

Inclusion for Therapy:

TREATMENT:

Patients must have **positive diagnostic test** for SARS-CoV-2 with onset of symptoms within **10 days** of planned administration

AND

Weigh ≥ 40 kg

AND

Un-vaccinated OR partially/fully vaccinated (including boosters) and NOT expected to host an adequate response

AND

Fit at least **ONE** of the following criteria:

___ Age ≥ 65 years

___ Patients aged 18 years or older **AND** 1 or more high-risk criteria (*listed below*)

___ 12-17 years **AND** one of the following or one of the high-risk criteria listed below:

___ BMI 85th percentile for height and weight based on CDC growth chart

___ Asthma or chronic respiratory disease that requires daily medication for control

Any pediatric patients referred to the program will be reviewed in conjunction with our pediatric infectious diseases colleague



HIGH RISK CRITERIA

___ BMI > 25

___ Chronic Kidney Disease (*eGFR < 50*)

___ Diabetes (*on long term oral medication(s) and/or insulin*)

___ Immunosuppressive disease or immunosuppressive treatment

___ Chronic lung disease (*Ex: COPD, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis, and pulmonary hypertension*)

___ Cardiovascular disease (*including congenital heart disease*) Of HTN

___ Sickle cell disease

___ Pregnancy

___ Neurodevelopmental disorders (*Ex: cerebral palsy*) or other conditions that confer medical complexity (*Ex: genetic or metabolic syndromes, and severe congenital anomalies*)

___ Having a medical-related technological dependence (*Ex: tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)*)

PROPHYLAXIS:

Post-exposure prophylaxis of COVID-19 in individuals (*12 years of age and older weighing >40 kg*) who are at high risk for progression to severe COVID-19, including hospitalization or death, and are:

___ not fully vaccinated OR who are not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination (*Ex: individuals with immunocompromising conditions including those taking immunosuppressive medications*)

AND

have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per CDC

OR

who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of COVID-19 infection in other individuals in the same institutional setting (*for example, nursing homes, prisons*)