CUMBERLAND EMERGENCY MEDICAL SERVICES
MONOCLONAL ANTIBODY THERAPY FOR SARS-COV-2
MEDICAL ORDER

Healthcare Provider:

Monoclonal antibody infusions are authorized under a Food and Drug administration (FDA) emergency use authorization (EUA). Please review the contraindications below before referring your patient for an infusion:

1. Patients who are hospitalized due to COVID-19.
2. Patients who require oxygen therapy due to COVID-19.
3. Patients requiring 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.
4. Known hypersensitivity to casirivimab or imdevimab.

PATIENT INFORMATION

Name _____ DOB _____

Street _____ City/town _____

Insurance _____ Policy # _____ Group _____

[If policy holders name is different from patient, please provide policy holders name and DOB]

Policy holder _____ DOB _____

Contact number to schedule appointment _____

MEDICAL HISTORY

ALLERGIES: _____

PMH:

COVID-19 RELATED INFORMATION

Date of symptom onset _____

Date of first positive COVID-19 test _____

Is the patient on oxygen at home? ____ YES ____ NO

If yes, what is the patients baseline requirement in LPM? _____ LPM

HIGH RISK CONDITIONS

Please check all that apply (other conditions may also put the patient into the high-risk category).

____ Age ≥ 65 yo
____ Diabetes
____ CKD
____ CAD
____ HTN
____ CHD
____ Sickle cell disease
____ BMI >25 kg/m2
____ Pregnancy
____ COPD
____ Asthma
____ Tracheostomy
____ Gastrostomy
____ Vent dependent
____ Pulmonary HTN
____ Metabolic syndrome
____ Pulmonary HTN
____ Cystic fibrosis
____ Cerebral palsy
____ Neurodevelopmental disorder
____ Immunosuppression
____ Interstitial lung disease
____ Other (please specify):
_____

[CONTINUED ON REVERSE]

PROVIDER INFORMATION

Name _____ Phone _____

NPI# _____ EMAIL OR FAX _____

PROVIDER DECLARATION AND MEDICAL ORDER

I confirm that this patient or their legal representative has received a full explanation of the nature, purpose, and risks associated with receiving of monoclonal antibody therapy. The patient has confirmed that he/she has received answers to all his/her questions, and to the best of my knowledge, I believe the patient has been adequately informed and has consented.

I hereby order that this patient receive one dose of CARS-CoV-2 monoclonal antibodies [600 mg casirivimab/600 mg imdevimab] IV.

Ordering Providers Signature _____ Date _____

ONCE COMPLETED AND SIGNED BY THE PROVIDER, PLEASE EMAIL THIS FORM TO EMS@CUMBERLANDRI.ORG OR FAX TO 401-334-3113. Please call 401-334-3090 extension 6 to confirm receipt.