

**Referral Form for UVA COVID-19 Clinic Antibody Infusion/ Injection for Adults with COVID-19**  
**Fax to 434.243.9800**

Eligible patients can be referred to the UVA COVID-19 clinic for intravenous infusion/ subcutaneous injection of investigational monoclonal antibody therapy under an FDA Emergency Use Authorization.

**ELIGIBILITY:**

Outpatients with COVID-19 and mild-to-moderate symptoms  $\leq 10$  days, without new or increasing oxygen requirement, and at greater risk for developing more serious symptoms that may require hospitalization, such as:

- Age 65 years and older
- A body mass index (a body-fat measurement based on height and weight) of 25 kg/m<sup>2</sup> or higher
- Chronic kidney disease
- Diabetes
- Pregnancy
- Immunosuppressive disease or immunosuppressive treatment
- Heart or cardiovascular disease, high blood pressure
- Chronic obstructive pulmonary disease (COPD) or other chronic respiratory diseases
- Sickle cell disease
- Neurodevelopmental disorders or having medical-related technological dependence

Post-exposure prophylaxis can also be considered in those at high risk of progression to severe COVID-19 who are not fully vaccinated (or who are not expected to mount an adequate immune response to vaccination) and close contact of/ at high risk of exposure to someone infected with COVID-19.

**REFERRAL:**

To initiate a referral for monoclonal antibodies at UVA, complete this form and fax to **434.243.9800 with a copy of the patient's insurance card**. The COVID clinic infusion team will review the referral form upon receipt and contact the patient to coordinate services as soon as possible. Patients prioritized for monoclonal antibodies will receive this therapy during an appointment at the UVA COVID-19 Clinic. Clinic appointments typically take 2-4 hours and are scheduled Mondays-Fridays each week. As therapy should be administered as soon as possible after a positive test result and within 10 days of symptom onset, it is recommended that your patient be referred as soon as possible. You can call the COVID-19 clinic 434.982.6843 with questions about referrals.

**DEMOGRAPHIC INFORMATION:**

Date of referral	
Patient Name	
Patient DOB	
Preferred Language	
Address	
Best Contact number	

**PERTINENT MEDICAL INFORMATION:**

Please include any additional information re: patient's health history and medication history. You may free text here or you attach a document that includes current problem list, health history (major surgeries, major illnesses), current medication list, and medication/food allergies:

**COVID-19 VACCINATION STATUS:**  Fully immunized  Partially immunized  Not immunized

Name of COVID vaccine(s) given and dates received: \_\_\_\_\_

**MONOCLONAL ANTIBODY ELIGIBILITY CRITERIA:**  Treatment  Post-exposure prophylaxis, exposure date: \_\_\_\_\_

Age: \_\_\_\_\_ years      BMI: \_\_\_\_\_ kg/ m<sup>2</sup>      weight: \_\_\_\_\_ kg

SARS-CoV2 test result (please include copy of result):  PCR  Antigen  positive  negative Date: \_\_\_\_\_

Symptoms: \_\_\_\_\_  Asymptomatic

Symptom onset date: \_\_\_\_\_ [Patients with severe symptoms should seek emergency medical attention]

SpO<sub>2</sub>: \_\_\_\_\_  On RA  On chronic O<sub>2</sub> therapy – Baseline O<sub>2</sub> Flow rate: \_\_\_\_\_

**High Risk for Severe COVID Illness (check all that apply):**

- Immunocompromised condition or immunosuppressive treatment/Specify (e.g. leukemia, lymphoma, organ transplant, stem cell transplant, HIV/CD4<200, chronic steroid, immunomodulator): \_\_\_\_\_
- Age ≥ 65 y/o  BMI ≥ 25 kg/m2  Pregnancy  Diabetes  Sickle cell disease  Chronic kidney disease  HTN
- Cardiovascular Disease /Specify (e.g. CAD, cardiomyopathy, arrhythmia/ congestive heart failure): \_\_\_\_\_
- COPD/other chronic respiratory disease/ Specify (e.g., CF, mod-to-severe asthma, pulmonary hypertension, interstitial lung disease): \_\_\_\_\_
- Neurodevelopmental disease (e.g. cerebral palsy) or other conditions that confer medical complexity (e.g., genetic or metabolic syndromes and severe congenital anomalies)
- Medical technological dependence e.g., trach, g-tube, or PPV  Other/Specify: \_\_\_\_\_

**CONTRAINDICATIONS:** Has patient had a prior severe hypersensitivity reaction, including anaphylaxis, to a COVID monoclonal antibody product (e.g., casirivimab, imdevimab, bamlanivimab, etesevimab, sotrovimab)? Yes No  
Does the patient have new/ increase in O2 flow rate since becoming symptomatic with COVID? Yes No

**REFERRING PROVIDER AGREEMENTS:**

I, the referring provider, am the patient’s PCP or other continuity provider and have arranged for the patient to follow up with me/my designee following Antibody treatment. Or I am an ED or Urgent Care provider who will update the patient’s PCP about the patient’s Antibody treatment in order to arrange follow up. If the patient does not have a PCP, I will refer him/her to an appropriate provider and ensure that follow up has been arranged.

Indicates Provider Agreement

I, the referring provider, have communicated to the patient or parent/caregiver, as appropriate, information consistent with the “Fact Sheet for Patients, Parents and Caregivers” (sheets will be provided in clinic) including:  
1. Monoclonal antibodies are FDA unapproved medications authorized for the emergency use of the treatment of mild-to-moderate COVID/ post exposure prophylaxis in those who are at high risk for progressing to severe COVID-19 and/or hospitalization. The potential risks and benefits are unknown, alternatives discussed and the patient/ current medical decision maker has the option to accept or refuse this treatment  
2. Treated patients should continue to self-isolate and use infection control measures according to CDC guidelines.  
3. The patient/current medical decision maker elected to proceed with treatment and has been Informed to report all adverse reactions to a healthcare provider

Indicates Provider Agreement

I, the referring provider, have advised the patient that if his/her clinical status declines by the time of the monoclonal antibodies appointment, the treatment may no longer be appropriate. I will update the clinic of any clinical changes such as new positive test. The patient’s clinical status will be re-evaluated at the infusion center at the appointment time. If the patient is deemed in need of hospital care, patient will be referred immediately.

Indicates Provider Agreement

Name of Referring Site:

Name of Referring Provider: Address: Point of Contact: Phone Number: Fax Number: <input type="checkbox"/> Check this box if the referring site is a Dept of Behavioral Health and Developmental Services (DBHDS) facility
--

The COVID Clinic staff will communicate with the referring provider regarding such matters as treatment inappropriateness for patient, ultimate completion of treatment for patient, adverse events.

**RESOURCES:**

Product administered based on availability of medication and logistics.  
Information about both medications, including Fact Sheets and Manufacturer Instructions/Package Inserts for Healthcare Providers and for Patients/Parents/Care Givers, can be found at <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs> (scroll to section on Drugs and Biologic Products).