Patient Name:_____
Patient DOB: _____

Mobile Integrated Healthcare
Covid Response Team

ALERT AMBULANCE SERVICE, INC.
MONOCLONAL ANTIBODY TREATMENT FOR SARS-COV-2
MEDICATION ORDER FORM
Version 9.20.21

ONCE COMPLETED AND SIGNED BY PROVIDER PLEASE FAX THIS FORM TO 1-401-574-2045 OR VIA SECURE E-MAIL TO AlertMIHC@AlertEMS.com

Dear Provider: Thank you for considering your patient for a monoclonal antibody treatment against SARS-CoV-2 as an outpatient treatment that may decrease chance of hospitalization for COVID-19. Monoclonal antibody infusions are authorized under an FDA Emergency Use Authorization {EUA) are **not indicated in patients requiring supplemental oxygen above their baseline (if on baseline 02, no increase in liters) or in those meeting criteria for hospitalization.** Due to limited supply, **patients most likely to benefit will be prioritized.**

PATIENT DEMOGRAPHIC INFORMATION		
Name:	**DOB:**	**Age:**
Gender:	**Race:**	**Phone:**
Address/City/Zip:		
Insurance 1:	**Policy#:**	**Group#:**
Insurance 2:	**Policy#:**	**Group#:**
If patient over 65 & has Blue Chip, UHC, Tufts - SSN# or Medicare #:		
If Policy holders Name is Different:	**Name:**	**DOB:**
Patient Scheduling Contact Info:	**Name:**	**Phone:**
Patient surrogate decision-maker:	**Name:**	**Phone:**
ADDITIONAL PATIENT INFORMATION		
If patient is NON-Ambulatory, explain:		
Date of Symptom Onset (must be within 10 days of onset to qualify):		
Date of first positive test for SARS-CoV-2 or Date of Exposure:		
If patient is on home oxygen, what is their baseline requirement? (lpm)		
PATIENTS RELEVANT MEDICAL HISTORY		
Weight (kg):	**Height (in):**	**BMI:**
Current Medications:		
Past Medical History:		
Allergies:		
Is the patient pregnant?		

Patient Name:_____
Patient DOB: _____

ALERT AMBULANCE SERVICE
Mobile Integrated Healthcare
Covid Response Team

ALERT AMBULANCE SERVICE, INC.
MONOCLONAL ANTIBODY TREATMENT FOR SARS-COV-2
MEDICATION ORDER FORM
Version 9.20.21

PROVIDER INFORMATION		
Full Name:	**NPI#:**	**Phone:**
Address:		**Fax:**

PROVIDER MEDICATION ORDER

As the ordering provider, I attest that the above patient information is correct as of the date/time below. As the ordering provider I understand that the patient may receive any one of the three monoclonal antibody treatments listed below based on current supply:

☐ **Order SARS-CoV-2 monoclonal antibody once per protocol.**

- **casirivimab/imdevimab (Regeneron) once by IV infusion or by four subcutaneous injections**
- **OR bamlanivimab and etesevimab (Eli Lilly) once by IV infusion**
- **OR Sotrovimab (GSK) once by IV infusion**

Ordering Providers Signature:		
	Date:	**Time:**

PROVIDER DECLARATION

Whether provided in person or virtually, I confirm that this patient or legal representative has received a full explanation about the nature and purpose of monoclonal antibody treatment, the risks involved in receiving medications used for monoclonal antibody treatment, and treatment alternatives. The patient confirms 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.

Ordering Provider has reviewed FDA EUA with patient/caregiver and has (must select all below for eligibility):

☐ **Given the "Fact Sheet for Patients, Parents and Caregivers"**
☐ **Informed of alternatives to receiving the COVID-19 antibody treatment**
☐ **Informed that the COVID-19 monoclonal antibody is an unapproved drug that is authorized for use under this EUA**

Providers Declaration Signature:		
	Date:	**Time:**