



THUNDERMIST HEALTH CENTER

MONOCLONAL ANTIBODY TREATMENT FOR SARS-COV-2

MEDICATION ORDER FORM

ONCE COMPLETED AND SIGNED BY PROVIDER PLEASE FAX THIS FORM TO Fax 401-735-1060

Phone 401-235-6878

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 O2, 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:	Phone:	
Address/City/Zip:		
Referring provider Name:		
Referring provider Address:		
Phone #		
ADDITIONAL PATIENT INFORMATION		
Is patient ambulatory:		
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)		
Current symptoms? :		
PATIENTS RELEVANT MEDICAL HISTORY		
Weight (kg):	Height (in):	BMI:
Current Medications:		
Past Medical History:		
Allergies:		
Is the patient pregnant		

PROVIDER INFORMATION		
Full Name:	NPI#:	Phone:
Address:		Fax#
PROVIDER MEDICATION ORDER		
<p>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:</p> <p><input type="checkbox"/> Order SARS-CoV-2 monoclonal antibody once per protocol.</p> <ul style="list-style-type: none"> ● casirivimab/imdevimab (Regeneron) once by four subcutaneous injections 		
Ordering Provider Signature:		
	Date:	Time:
PROVIDER DECLARATION		
<p>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.</p> <p>Ordering Provider has reviewed FDA EUA with patient/caregiver and has (must select all below for eligibility):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Given the "Fact Sheet for Patients, Parents and Caregivers" <input type="checkbox"/> Informed of alternatives to receiving the COVID-19 antibody treatment <input type="checkbox"/> Informed that the COVID-19 monoclonal antibody is an unapproved drug that is authorized for use under this EUA 		
Providers Declaration Signature:		
	Date:	Time: