Pediatric Monoclonal/Antiviral Infusion Therapy External Referral Scheduling Request

Fax completed form and documents to 540-857-5309

Scheduling occurs AFTER all pages are received with all fields completed.

PATIENT INFORMATION

Patient's Full Name _____ Sex _____ Date of Birth _____

Street Address _____ SSN _____

City, State, Zip Code _____ Phone _____ BEST CONTACT

Legal Guardian Name _____ Alternate Phone _____

REQUESTING PROVIDER

***Providing contact numbers is crucial to confirm your request**

Provider Name _____ Back Office Phone* _____

Street Address _____ Office Fax* _____

City, State, Zip Code _____ Alternate/Cell Phone* _____

PATIENT ELIGIBILITY

Monoclonal antibody and antiviral infusions must be given within the time frame from symptom onset approved by the FDA. If patient does not meet this requirement, do not submit.

1. **Date of COVID-19 Symptom Onset**: _____
2. **Date of positive COVID-19 test:** _____
3. **Is the patient fully vaccinated?** ☐ **YES** ☐ **NO**
   ***Fully vaccinated against SARS-CoV-2 infection greater than or equal to 2 weeks after receipt of the second dose in a 2-dose series (Pfizer-BioNTech and Moderna) or greater than or equal to 2 weeks after receipt of a single dose of the Janssen COVID-19 vaccine*
4. **Does patient require oxygen (or increased oxygen need from baseline) due to COVID-19?** ☐ **YES** ☐ **NO**
   ***Not authorized for patients requiring NEW oxygen therapy or increased oxygen from baseline due to COVID-19*
5. **Is the patient at high risk for progressing to severe disease?** ☐ **YES** ☐ **NO**
6. **Did you discuss with the patient/caregiver that the available monoclonal antibodies are investigational and under Emergency Use Authorization (EUA) and included aforementioned documentation in your note/EMR?** ☐ **YES** ☐ **NO**
7. **Please check all applicable patient criteria below:**

Asthma or Chronic Lung Disease	☐	**Pregnancy (discuss with OB)**	☐
BMI of 35 or greater, or greater than 85%ile for age	☐	**Sickle Cell Disease**	☐
Cardiovascular Disease, Hypertension, or Heart Disease (Congenital or Acquired)	☐	**Neurodevelopmental disorders (e.g., Cerebral Palsy)**	☐
Chronic Kidney Disease	☐	**Medical-related technology dependence (trach, pos pressure ventilation)**	☐
Diabetes	☐	**Taking Chloroquine**	☐
Immunosuppressive Disease and/or Therapy	☐	**Taking Hydroxychloroquine**	☐

☐ Abbreviated H&P w/ past medical history & medication list attached

☐ If available: COVID test result attached *(screenshot or photo is acceptable)*

PATIENT IDENTIFICATION

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REFERRING PROVIDER AGREEMENTS:

I, _____ *(printed name)*, the referring provider, have communicated to the patient or parent/caregiver, as appropriate, information consistent with the "Fact Sheet for Patients, Parents and Caregivers" including:

1. Monoclonal, antiviral and other COVID-19 therapeutics will be given interchangeably as appropriate for patient as published in the NIH COVID-19 treatment guidelines, some of which may be off-label or under FDA emergency use authorization.
2. The potential risks and benefits are not completely known.
3. The patient or parent/caregiver has the option to accept or refuse this treatment, and alternatives were discussed.
4. Treated patients should continue to self-isolate and use infection control measures according to CDC guidelines.

☐ **Indicates Provider Agreement**

I, the referring provider, certify that the patient has a positive covid test (antigen and PCR accepted).

☐ **Indicates Provider Agreement**

I, the referring provider, have advised or will advise the patient that if his/her clinical status declines by the time of the infusion appointment, the treatment may no longer be appropriate for him/her. 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, she/he will be referred immediately.

☐ **Indicates Provider Agreement**

Please note orders will be discontinued if the infusion is not administered on the day of the appointment.

Provider Signature _____ Date _____ Virginia Medical License Number _____ Exp. Date _____

PATIENT IDENTIFICATION

Pediatric Monoclonal/Antiviral Infusion Therapy External Referral Order Form

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PATIENT INFORMATION

Patient's Full Name | Sex | Date of Birth

Street Address | SSN

City, State, Zip Code | Phone BEST CONTACT

Legal Guardian Name | Alternate Phone

REQUESTING PROVIDER

***Providing contact numbers is crucial to confirm your request**

Provider Name | Back Office Phone*

Street Address | Office Fax*

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The CONSULT TO PHARMACY TO DOSE OUTPATIENT COVID-19 MEDICATION choice will be based on inventory availability at infusion sites and variant strains. The following medications or any medications available and listed as approved on the NIH COVID treatment guidelines panel statement on therapies for high-risk, non-hospitalized patients with mild to moderate COVID-19 may be selected for treatment:

- Sotrovimab 500 mg IVPB in NS 0.9% in 108 mL once
- Bebtelovimab 175mg IVP x1 over at least 30 seconds
- Casirivimab 600 mg/Imdevimab 600 mg IVPB in NS 0.9% 110 mL once
- Bamlanivimab 700 mg/Etesevimab 1400 mg IVPB in NS 0.9% in 160 mL once
- Remdesivir 200 mg IVPB in NS 0.9% 100 mL on day 1, followed by 100 mg IVPB in NS 0.9% 100 mL on day 2 and day 3

One of the following options will be entered:

1. EUA Monoclonal Antibody therapy (Sotrovimab, Bebtelovimab, Casirivimab/Imdevimab, or Bamlanivimab/Etesevimab):

For patients 18 years of age and older:

- IP-FDA EUA COVID-19 MONOCLONAL ANTIBODY INFUSION FOR MILD-MODERATE COVID-19 INFECTION
- IP MED: ADVERSE INFUSION REACTION (TREATMENT)

For patients 12-17 years of age:

- IP-PED: FDA EUA COVID-19 MONOCLONAL ANTIBODY INFUSION FOR MILD-MODERATE COVID-19 INFECTION (AGE 12-17 YEARS)

2. Remdesivir therapy:

For patients 12 years and older and at least 40 kg:

- IP-PHR: REMDESIVIR FOR NON-HOSPITALIZED PATIENTS 12 YEARS OF AGE OR OLDER
- IP MED: ADVERSE INFUSION REACTION (TREATMENT)

If infusions are not infused on day of appointment, orders will be discontinued by infusion center nursing staff.

Provider Signature | Date | Virginia Medical License Number | Exp. Date

PATIENT IDENTIFICATION

CARILION CLINIC

CMC - CRMH CMC - CRCH CFMH CGCH CNRV CRBH CTCH