COVID-19 OUTPATIENT INFUSION CENTER
MONOCLONAL ANTIBODY PATIENT SCREENING FORM

CovenantHealth

PATIENT INFORMATION

Name: _____ Sex: M / F Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: Secondary _____

Primary Insurance: _____ Insurance: _____

This form is utilized to screen patients as possible candidates to receive treatment in the COVID-19 outpatient infusion center. After receiving this form, the labs (if not available) will need to be drawn in the medical tent under the referring physician prior to determining if the patient is able to receive treatment. Those labs are CMP, CBC, LDH, CRP and D-Dimer. Treatment in the infusion center may not be appropriate in the following situations:

- WBC is rising rapidly and more then 16,000
- AST/ALT is greater than 400
- D-Dimer is greater than 3
- CRP or LDH is trending up rapidly and it is greater than 100

Once the labs and screening form have met criteria, a provider at the COVID-19 outpatient infusion center will evaluate the patient's condition and past medical history along with the availability of resources to determine if therapy is appropriate. Not all patients referred to center will receive treatment. If the patient is not approved for treatment, the center provider or their delegate will contact the patient to inform them of this decision and with further instructions on managing their disease.

Patients may have a different response to the medications that are provided and, unfortunately, some will deteriorate and need additional care. To provide safe care for our patients outside of their time in the center, we will require the following:

- The patient has access to pulse oximeter, thermometer, and reliable transportation.
- The patient has an adequate home environment for monitoring (should preferably live with someone who can recognize adverse effects or worsening of clinical status).
- The patient lives within 1 hour of an acute care facility in case the patient's condition deteriorates and needs more intense care.

☐ BAMLANIVIMAB TREATMENT - OR - ☐ CASIRIVIMAB AND IMDEVIMAB TREATMENT

To qualify for therapy, the patient must meet ALL of the requirements below.

☐ The first positive COVID-19 test was within the last 5 days. Date of test _____

☐ The date from symptom onset is within 10 days. First date of symptoms _____

☐ The patient does NOT require hospitalization OR supplemental oxygen therapy beyond their baseline need for COVID-19.

☐ Is the patient high risk?
High risk is defined as patients who meet at least one of the following criteria:

- Have body mass index (BMI) greater than or equal to 35
- Have chronic kidney disease
- Have diabetes
- Have immunosuppressive disease
- Are currently receiving immunosuppressive treatment
- Are greater than or equal to 65 years of age
- Are greater than or equal to 55 years of age AND have:
  - cardiovascular disease, OR
  - hypertension, OR
  - COPD/other chronic respiratory disease
- Are 12-17 years of age AND have
  - BMI greater than or equal to the 85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm , OR
  - sickle cell disease, OR
  - congenital or acquired heart disease, OR
  - neurodevelopmental disorders, for example, cerebral palsy, OR
  - a medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive ventilation (not related to COVID-19), OR
  - asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

The pharmacy will substitute the alternative monoclonal antibody if the selected product is out of stock.

PHYSICIAN INFORMATION

As the referring physician, I verify that the information on this screening form is accurate to the best of my knowledge. I have also made the patient aware that they will be screened by a provider at the infusion center who will determine if the treatment is appropriate before they will be approved to receive treatment.

Printed Name: _____ DEA/NPI: _____

Signature: _____ Date: ____/____/____

Please fax a copy of this screening form to (806) 723–6073 and call our COVID Center nurse at (806) 725–7200 to notify them the screening form has been submitted.