Place Patient Label Inside This Box

Referral for Casirivimab/Imdevimab Infusion at MMH

Patient Name: ______________________________ DOB: _______/________/_______

Phone Number: ______________________________ Allergies: __________________________

Height: ______________________________ Weight: ______________________________

Must be Positive for COVID-19 and within 5 days of symptoms onset

Date of Positive COVID Test: _______/________/_______ Testing Site: ____________________________

Date of Symptom Onset: _______/________/_______ ICD 10 Diagnosis Code: U07.1__________

Exclusion Criteria: Use of supplemental oxygen, hospitalization

Mark All Applicable Indications

Risk Factors for progression to severe COVID-19:

- ☐ Older age (for example age ≥65 years of age)
- ☐ Obesity or being overweight (BMI > 25 kg/m^2)
- ☐ Pregnancy
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease or immunosuppressive treatment
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- ☐ Sickle cell disease
- ☐ Neurodevelopmental disorders or other conditions that confer medical complexity
- ☐ Having a medical-related technological dependence (examples – tracheostomy, gastrostomy, etc.)
- ☐ *Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19 and authorization of casirivimab and imdevimab under the EUA is not limited to the medical conditions or factors listed above.*

Completion of Referral

☐ Patient received *Casirivimab/Imdevimab Fact Sheet for Patients, Parents, and Caregivers*

Provider Name: ______________________________ Phone Number: ____________________________

Provider Signature: ______________________________ Date:______ /_______ /_______ Time: ___________

Please call to schedule at 1-866-415-2778,
then fax the completed referral form to Centralized Scheduling at 910-715-1177.

Please call 910-571-5336 with questions or concerns.