COVID-19: ADULT MONOCLONAL MEDICATION REQUEST FORM

Please PRINT legibly (fax #: 484-227-9028)

Ordering Provider Name: _____Cell phone # (required): _____

Provider's email: _____Office Phone #: _____

Are you this patient's Primary Care Provider? ☐ Yes ☐ No MLH Medical Staff: ☐ Yes ☐ No

If not, please provide the patient's primary provider information (if they have one):

Name _____ Phone #: _____

Patient Information:

Last Name: _____ First Name:_____ DOB:_____

Cell phone #: _____ Email: _____

Essential Worker (required): ☐ Yes ☐ No Occupation (required): _____

Address(Street):_____Apt:_____

City: _____ State: _____ Zip (required): _____

Medical Information:

MLH MRN# (if known): _____

Past Medical History:

_____

Life Expectancy: Individuals expected to die within one year or less (≤ 1 Year) from a chronic, end-stage condition prior to developing COVID-19 (required)? ☐ Yes ☐ No

If Yes, please provide clinical reason: _____

Positive COVID-19 test result (required): _____ Date: _____ (*Attach Copy of Result*)

- ONSET of Covid-19 related symptoms (Date)_____

Inclusion Criteria:

Within 10 days of onset of symptoms, +PCR, non-hospitalized plus ONE of the following (1-6):

1. Age ≥ 65 ☐ Yes ☐ No
2. BMI ≥ 25 ☐ Yes ☐ No BMI (required): _____
3. Diabetes ☐ Yes ☐ No
4. Chronic Kidney Disease ☐ Yes ☐ No

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5. Sickle cell disease ☐ Yes ☐ No
6. Pregnancy ☐ Yes ☐ No
7. Immunosuppressive disease or immunosuppressive treatment ☐ Yes ☐ No
   If Yes, what therapy is the patient currently receiving _____
8. Cardiovascular disease (including congenital heart disease) or HTN ☐ Yes ☐ No
9. Chronic lung disease (i.e. COPD, asthma [mod-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension) ☐ Yes ☐ No
10. Neurodevelopmental disorders (i.e. cerebral palsy) or other conditions that confer medical complexity (i.e. genetic or metabolic syndromes and severe congenital anomalies)
    ☐ Yes ☐ No
11. Have a medical-related technological dependence (i.e. tracheostomy, gastrostomy, or positive pressure ventilation [not related to COVID-19]) ☐ Yes ☐ No
12. Social determinants of health which have been shown to independently negatively impact survival from COVID-19 ☐ Yes ☐ No
    a. If Yes, please describe _____

I hereby verify the following:

- The patient meets the requirements as defined by MLH inclusion and exclusion criteria.
- The Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) was reviewed with the patients who is willing to undergo treatment if selected.
- If no test is included, you have spoken to the patient to ensure that the test will be provided to their primary provider to ensure that the Monoclonal Antibody Therapy team can obtain the test.
- Patients may need to be allocated monoclonal antibody therapy via weighted lottery based on patient eligibility and availability of infusion resources (for this reason, you have included all of the information requested on this form).

Your submission and signature on this document indicate that, per your knowledge, the patient does not meet the exclusion criteria, listed below:

a) Anticipated hospital admission due to COVID-19
b) Required oxygen therapy due to COVID-19
c) Required an increase in baseline oxygen flow rate due to COVID-19.
   *Treatment with monoclonal antibody therapy has not been studied in patients hospitalized due to COVID-19 and may be associated with worse clinical outcomes when administered to hospitalized patients with COVID-19 requiring high flow oxygen or mechanical ventilation

Signature of Provider: _____ Date: _____