Yale NewHaven Health

Outpatient Referral Requisition Form for COVID-19 Monoclonal Antibody Therapy

Please fax to: 475-246-9923

Referring Clinician Information:

Clinician name_____ Clinician phone number_____

Patient Information:

Last name_____ First name_____

Address_____City_____State_____Zip_____

Date of birth_____Phone number_____

EPIC MRN (if available) _____

Date of COVID-19 Positive test result_____ (patient only eligible if positive within the last 7 days)

In order for the patient to be eligible for bamlanivimab or casirivimab/imdevimab patients have to meet one of the following criteria. Please select which of the following criteria the patient meets:

- ☐ Patient is ≥ 75 years of age

Patient is < 75 years of age AND has one of the following co-morbidities:

- ☐ Chronic Kidney Disease, Stage III or higher or receiving dialysis
- ☐ Congestive Heart Failure NYHA Class III or higher
- ☐ Severe pulmonary disease defined as one of the following: COPD with continuous home oxygen, pulmonary hypertension or pulmonary fibrosis, cystic fibrosis
- ☐ One of the following hematologic/oncologic diagnoses: S/P stem cell transplant or active chemotherapy for acute leukemia, lymphoma, or myeloma
- ☐ S/P solid organ transplant
- ☐ Immunosuppressive therapy defined as: receiving or have received lymphocyte depleting monoclonal antibody therapy (e.g., rituximab, ofatutumab, ocrelizumab, alemtuzumab, etc.)
- ☐ Parkinson's disease

Patient aged 12-17 with one of the following:

- ☐ Congenital or acquired heart disease
- ☐ Neurodevelopmental disorders
- ☐ Medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
- ☐ Chronic respiratory disease excluding asthma

Please also confirm you have completed the following:

- ☐ Verified that patient meets criteria for infusion at this time as indicated on the information above (patient can only be offered infusion for criteria outlined at this time).
- ☐ Obtained verbal informed consent for the infusion.
- ☐ If approved, inform the patient to expect a phone call from a YNHHS number with scheduling information.
- ☐ I provided the patient education for the bamlanivimab or casirivimab/imdevimab therapy.

Provider signature _____ Date: _____