Main Line Health®

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): _____

Nursing Home/ Facility? _____

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: _____ Date: _____ (*Attach Copy of Result*)

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

*A COVID-19 test is required for the indication to treat mild to moderate disease, but not required for prophylaxis after an exposure.

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Inclusion Criteria for patients diagnosed with COVID-19 and at high risk to progress to severe COVID-19:

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
5. Sickle cell disease ☐ Yes ☐ No
6. Pregnancy ☐ Yes ☐ No

7. Immunosuppressive disease, condition, or immunosuppressive treatment ☐ Yes ☐ No
   If Yes, what condition and treatment 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 _____

For post-exposure prophylaxis, in addition to the inclusion criteria above, please answer the following questions: Is this a request for Prophylactic Therapy? YES ☐ No ☐

If YES, Select ONE	
☐ Patient is NOT fully vaccinated	☐ Patient is not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination (for example, people with immunocompromising conditions, including those taking immunosuppressive medications)
AND	
Select ONE	
☐ Patient has been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per Centers for Disease Control and Prevention (CDC) **defined as** anyone who was within 6 feet of an infected person for a total of 15 minutes or more.	☐ Patient is high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, nursing homes or prisons)
Please define the exposure:	

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Is this patient at risk for <u>ongoing</u> exposure for > 4 weeks?

☐ YES ☐ NO

I hereby verify the following:

- The patient meets the requirements as defined by the U.S. FDA EUA to permit the emergency use of the unapproved product (the inclusion criteria as listed above) and found at the following link: https://www.fda.gov/media/145611/download
- The Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) was reviewed with the patient who is willing to undergo treatment if they meet criteria (or selected when the lottery is deployed).
- If patient has a positive test, have patient provide test to PCP or include the test with this document submission to support the Monoclonal Antibody Therapy team in triage of the patient for therapy (unless the treatment is indicated for post-exposure prophylaxis).
- 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 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.

Signature of Provider: _____ Date: _____