COVID-19: PEDIATRIC 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 #: _____

Pediatric and Patient Information:

Patient's last name: _____ Patient's first name: _____

DOB: _____

Address (Street):_____Apt:_____

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

Parent's last name_____ Parent's first name:_____

Parent's Cell Phone # (*required*): _____

Parent's email: _____

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)_____

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Inclusion Criteria:

1. 12-17 y.o. and one of the following: (*please select at least one of the following*)
    a. ☐ BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm
    b. ☐ Sickle cell disease
    c. ☐ Congenital or acquired heart disease
    d. ☐ Neurodevelopmental disorders (i.e. cerebral palsy)
    e. ☐ Medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
    f. ☐ Asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

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 patient who is willing to undergo treatment if selected.
- The patient understands that there is a limited supply of the monoclonal antibody medication used to treat COVID-19 under the EUA, and therefore the patient may not receive it.

Your submission and signature on this document indicates that the patient does not meet any of the following EXCLUSION criteria listed below:

a) Anticipated hospital admission
b) Hypoxia <92%, PaO2/FiO2 <300, RR >30, HR> 125bpm
c) Required or anticipated vent support
d) Hemodynamic instability
e) Suspected associated bacterial, viral fungal infections other than COVID-19
f) Comorbidity requiring surgery in the previous 7 days or ICU admission in the prior 30 days
g) History of prior positive COVID-19 serology or positive diagnostic test prior to the current positive test being used to consider therapy
h) Pregnant or breastfeeding
i) ≤ 40 kg

Signature of Provider: _____ Date: _____