McLeod Health

The Choice for Medical Excellence

Bamlanivimab/Etesevimab Referral Form

DATE:_____

Please complete & fax to the COVID Call Center at **843-777-9755** with a copy of positive COVID-19 result if available.

Patient Name: _____ **Date of Birth: _____**

Allergies: _____ **Patient Email: _____**

Contact Number (Patient/Caregiver): _____

Date of symptom onset (must be within the last 10 days): _____ **Date of Positive Test: _____**

Diagnosis: COVID-19 – ICD 10: U07.1

Ht: _____in **Wt: _____kg** **BMI: _____**

Indication:
Emergency Use Authorization (non-FDA approved) for treatment of mild to moderate COVID-19 illness

Verify that the patient meets the criteria below by checking the boxes:

- ☐ symptom onset within **less than 10 days** (asymptomatic patients should not be referred)
- ☐ high risk of progressing to severe COVID-19 and/or hospitalization defined by (**check at least one**):
  - ☐ ≥ 65 Years of Age (Tier1)
  - ☐ ≥18 Years of Age **AND** BMI ≥ 35 (Tier 2)
  - ☐ 55-64 Years of Age **AND** hypertension, cardiovascular disease, or chronic respiratory disease (Tier3)
  - ☐ ≥18 Years of Age **AND** Chronic Kidney Disease, Diabetes, or immunosuppressive disease/therapy (Tier 4)

Confirm that patient has received the EUA Fact Sheet for Patients and Caregivers (attached). If hard copy cannot be provided it will be provided at the infusion site but **please check box below to confirm patient understands and has consented**.

- *"I verbally provided the patient/caregiver the information contained in the bamlanivimab/etesevimb fact sheet for patients and parents/caregivers including that the FDA has authorized the emergency use of this therapy for COVID-19. The patient/caregiver had the option to accept or refuse treatment. Information was provided about the significant and known potential benefits and risk and the extent to which such risks and benefits are unknown. After discussing this information with the patient/caregiver, the patient/caregiver agreed to begin treatment."*

Referring Provider Signature :_____

Provider Name & Contact Information: _____

Please note patients are scheduled based on appointment availability, drug allocation, and patient criteria including tier and symptom onset date. All requests may not be able to be accommodated. Referring provider will be notified if the patient cannot be scheduled. If you have any questions, please contact the COVID Call Center at 843-777-2919 and press 5.

3/22/2021