

## Casirivimab and Imdevimab referral for Outpatient SQ injection for Post-Exposure Prophylaxis

The FDA has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product casirivimab and imdevimab for post-exposure prophylaxis coronavirus disease 2019 (COVID-19) in who are at high risk for progressing to severe COVID-19 and/or hospitalization.

**Please fill out the form in its entirety. The referral is invalid if information is missing or illegible.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: \_\_\_\_\_  in  cm      Weight: \_\_\_\_\_  lbs  kg      Allergies: \_\_\_\_\_

Diagnosis:  Prophylactic Monoclonal Antibody Injection – ICD-10 Code Z29.8

**Please attach the following to this referral:**

- Face sheet/Updated demographics

	Provider Initials	
Provider attests to have reviewed and complied with EUA criteria for prescribing casirivimab and imdevimab per Oregon and federal policies.		
Provider attests that patient (or legal representative) verbally consents to treatment with casirivimab and imdevimab.		
Provider attests that patient (or legal representative) understands the conditions of EUA (including risks, benefits, & alternatives to casirivimab and imdevimab) and that this medication is not FDA approved.		
Provider attests that patient (or legal healthcare representative) was given a physical copy of the FDA Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) of Casirivimab and Imdevimab for Coronavirus Disease 2019 (COVID-19).	This will be done at treatment	
	Yes	No
Is the patient fully vaccinated against SARS-CoV-2, i.e. 2 weeks after second dose of Pfizer or Moderna or after single dose Johnson & Johnson? (If yes, casirivimab & imdevimab is not indicated)	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient 12 years of age or older and weighs at least 40 kg?	<input type="checkbox"/>	<input type="checkbox"/>
Does patient meet at two of the required criteria and least one of the other criteria that defines them as high-risk (criteria on Page 2)?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient pregnant or breastfeeding? (If yes, provider attests that they have consulted OB, MFM, or ID regarding use and have discussed the risk vs benefits of use with the patient or legal representative)	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a history of a positive SARS-CoV-2 antibody? (If yes, casirivimab & imdevimab is not indicated)	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient received SARS-CoV-2 convalescent plasma or another SARS-CoV-2 monoclonal antibody? (If yes, casirivimab & imdevimab is not indicated)	<input type="checkbox"/>	<input type="checkbox"/>

Applegate Valley Family Medicine, LLC  
 8600 New Hope Rd  
 Grants Pass, OR 97527  
 (541) 862-AVFM (2836)  
 (541) 862-2806 Fax

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_ Diagnosis:  Prophylactic Monoclonal Antibody Injection – ICD-10 Code Z29.8

**High risk is defined as a patient who meet two of the required criteria and at least one of the following other criteria:**

- Required Criteria:
  - Not completely vaccinated **or** not expected to mount an adequate immune response to SARS-CoV-2 vaccination (e.g. individuals with immunocompromising conditions, including those taking immunosuppressive medications).
- AND**
- Exposed to an infected individual who has been lab-confirmed to have SARS-CoV-2 defined as having been within 6 feet of infected individual for 15 minutes over a 24-hour period in the 7 days after the infected individual was diagnosed.
- Other Criteria (must select as least one):
  - Overweight or Obesity (BMI  $\geq$  25 or If age 12-17, BMI  $\geq$  85<sup>th</sup> percentile for age and gender)
  - Chronic kidney disease
  - Diabetes
  - Immunosuppressive disease or receiving immunosuppressive treatment
  - Cardiovascular disease, Congenital heart disease, or Hypertension
  - Chronic lung disease (e.g. COPD, moderate to severe asthma, ILD)
  - Age  $\geq$  65
  - Sickle cell disease
  - Neurodevelopmental disorders (e.g. Cerebral palsy), congenital anomalies, or complex genetic/ metabolic syndromes
  - Pregnancy (with high risk factors)
  - Medical-related technology dependence (e.g. Tracheostomy, PEG tube or positive pressure ventilation not related to COVID-19)

Provider Name (Printed): \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Provider phone: \_\_\_\_\_

Fax completed for to Applegate Valley Family Medicine, LLC (541) 862-2806.

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