Casirivimab and Imdevimab referral for Outpatient SQ injection for COVID 19 Treatment

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: ☒ COVID-19, virus identified (lab confirmed) – ICD-10 Code U07.1

Please attach the following to this referral:

- Face sheet/Updated demographics
- Medical necessity and reason for patient classified as high-risk. See criteria on Page 2.

	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).	To be done at treatment	
	Yes	**No**
Does patient have a positive SARS-CoV-2 test result? Date of testing:_____	□	□
Is the patient within 10 days of symptom onset? Date of symptom onset:_____	□	□
Is the patient 12 years of age or older and weighs at least 40 kg?	□	□
Does patient require oxygen therapy due to COVID-19? (If yes, casirivimab & imdevimab is not indicated)	□	□
Does patient require an increase in baseline oxygen flow rate? (If yes, casirivimab & imdevimab is not indicated)	□	□
Does patient meet at least one of the criteria that defines them as high risk (criteria on Page 2)?	□	□
Is the patient pregnant or breastfeeding? (If yes, provider attests that they have consulted OB, MFM, or ID regarding use and have discussed risk vs. benefit of use with patient or legal representative)	□	□
Does the patient have a history of a positive SARS-CoV-2 antibody? (If yes, casirivimab & imdevimab is not indicated)	□	□
Has the patient received SARS-CoV-2 convalescent plasma or another SARS-CoV-2 monoclonal antibody? (If yes, casirivimab & imdevimab is not indicated)	□	□

Applegate Valley Family Medicine, LLC
8600 New Hope Rd
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(541) 862-AVFM (2836)
(541) 862-2806

Adapted from Asante Health System Forms

Casirivimab and Imdevimab Referral for Outpatient SQ injection for COVID treatment

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

Patient Name:_____DOB:_____Allergies:_____

Diagnosis: ☒ COVID-19, virus identified (lab confirmed) – ICD-10 Code U07.1

High risk is defined as a patient who meet at least one of the following criteria (must select at least one):

Overweight or Obesity (BMI > 25 or If age 12-17, BMI > 85th 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 > 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 form to Applegate Valley Family Medicine, LLC (541) 862-2806

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