To: All Physicians and Providers

From: Matthew Upton, MD

Date: 1/5/2021

Subject: Thomas Health Monoclonal Antibody Clinic

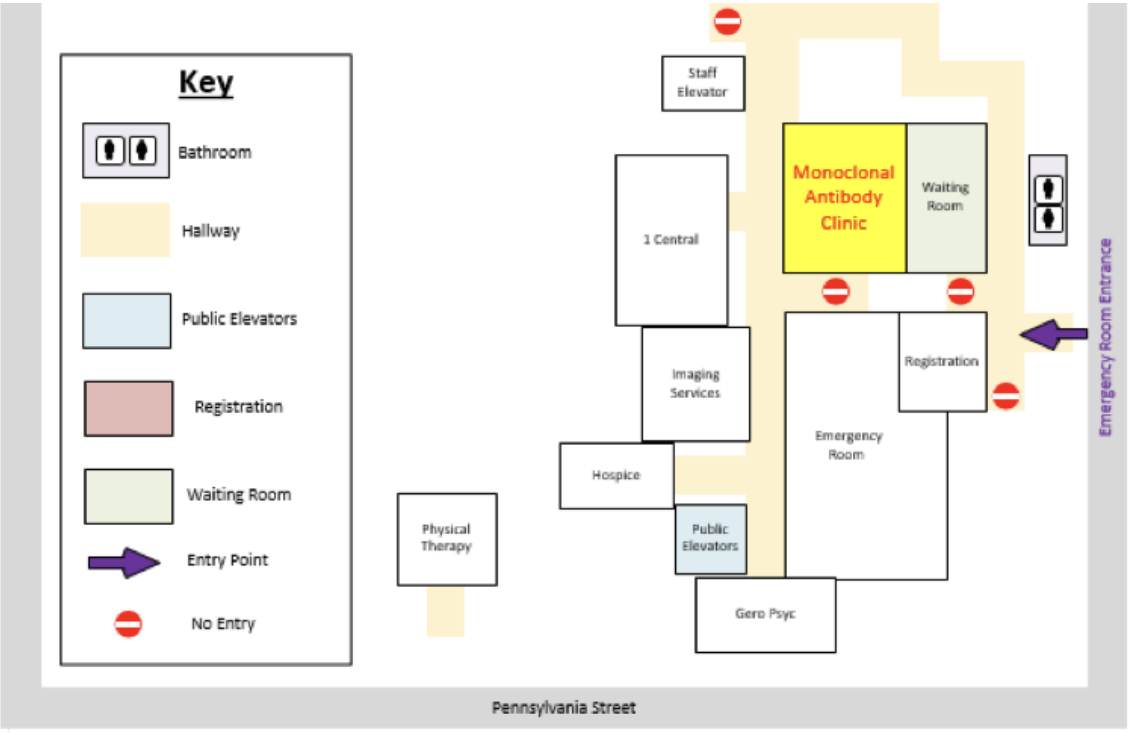
Thomas Health is pleased to announce the opening of our Monoclonal Antibody Clinic, located in the area adjacent to the Emergency Department (old Care Center 24), at Thomas Memorial Hospital.

When a patient is identified as meeting the criteria for antibody administration, your office needs to call Central Scheduling (304) 766-3726 and fax the order and financial information to (304) 766-3840. We will schedule them for an antibody infusion as quickly as possible. Patients are asked to wear a mask and only enter the facility at the Emergency Department entrance of the hospital; and follow the signage to check-in where they will be moved into the antibody clinic to complete any further paperwork.

Documents required, please fax to (304) 766-3840:

1. Criteria for Monoclonal Antibody Therapy (Criteria and Signed Order Form)
2. COVID Antibody Form (Patient and Insurance Information)
3. Copy of the patients COVID-19 Positive Lab Result (Antigen or PCR)

All required documents are also available at https://thomashealth.org/for-physicians/



Matthew Upton, MD
Thomas Health – CMO/CMIO

Monoclonal Antibody Therapy Infusion Order and Criteria

Monoclonal antibody therapy should be reserved for patients who the provider believes are at high risk for progressing to severe COVID-19 and/or hospitalization per criteria defined in the EUA as listed below. Utilization will be monitored and adjustments made to this criteria as resources change or as state/regulatory agencies deem appropriate. Patients receiving Monoclonal Antibody Therapy will need to enter through the Thomas Memorial Emergency Department.

Infusion is administered as soon as possible after a positive viral test for SARS-CoV-2 and within 10 days of symptom onset.

May NOT have any of the following:

Exclusion Criteria:

1. Patients hospitalized due to COVID-19
2. Patients requiring oxygen due to COVID-19 or an increase above their baseline
3. Age < 12 years old
4. Weight < 40kg (88 lbs)
5. Greater than 10 days of symptoms
6. Asymptomatic

Need ONE of the following:

Inclusion Criteria:

1. **Age 12-17**
   a. Asthma, reactive airway or chronic respiratory disease that requires daily medication for control
   b. Medical-related technological dependence such as tracheostomy, gastrostomy or positive pressure ventilation (not related to COVID)
   c. Neurodevelopmental disorders such as cerebral palsy
   d. Congenital or acquired heart disease
   e. Sickle cell
   f. BMI ≥ 85th percentile
2. **Age ≥ 12**
   a. Immunosuppressive disease or receiving immunosuppressive treatment
   b. Diabetes
   c. Chronic Kidney Disease
3. **Age ≥ 18**
   a. BMI ≥ 35
4. **Age ≥ 55**
   a. COPD
   b. Hypertension
   c. Cardiovascular disease
5. **Age ≥ 65**

◯ Bamlanivimab 700mg IV/ Etesevimab 1400mg piggyback once, infuse as per protocol.

Per Thomas Health approved therapeutic interchange, the patient may receive Casirivimab 1200mg / Imdevimab 1200mg IV piggyback once, infuse as per protocol.

Primary Diagnosis: Covid-19 Acute Infection Confirmed by PCR or Antigen Test **ICD10**: U07.1

I attest that at the time of ordering, the patient meets the above mentioned criteria for the EAU for Bamlanivimab/ Estesevimab **OR** Casirivimab/Imdevimab. **AND** that I have obtained informed consent from the patient.

Date: ____/_____/_____ Time: _____ AM/PM Signature: _____

ThomasHealth

COVID-19 MONOCLONAL ANTIBODY THERAPY

PLEASE FAX THIS FORM AND THOMAS HEALTH COVID-19 MONOCLONAL ANTIBODY INFUSION AND CRITERIA ORDER TO: 304.766.3840

PATIENT INFORMATION:

FIRST NAME: _____ M.I. _____ LAST NAME: _____

D.O.B.: _____ SSN (LAST 4 DIGITS): _____ MARITAL STATUS: S M W SEP

ADDRESS: _____ SEX: ☐ M ☐ F

CITY: _____ STATE: _____ ZIP CODE: _____

HOME/CELL PHONE: (_____)_____ WORK PHONE: (_____)_____

GUARDIAN/GUARANTOR: (IF UNDER 18 MUST BE ACCOMPANIED BY GUARDIAN TO INFUSION)

NAME: _____ D.O.B.: _____ RELATIONSHIP: _____

PROVIDER INFORMATION: ☐DO ☐NP ☐MD ☐PA

REQUESTING PROVIDER: _____ NPI#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (_____)_____ FAX: (_____)_____ AGENT: _____

INSURANCE INFORMATION: PLEASE INCLUDE A COPY OF THE CARD(S)

INSURANCE CARRIER: _____ POLICY #: _____

AUTHORIZATION #:_____ VALID THROUGH: _____

HOW MANY VISITS: _____

PLEASE ATTACH A FACESHEET AND COPY OF COVID-19 LAB TEST

APPOINTMENT DATE: _____ (DAY AND DATE)

TIME: _____ ☐ AM ☐ PM

DATE: _____ TIME: _____

SIGNATURE: _____

USE LABEL OR PRINT PATIENT ID HERE

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