To: All Physicians and Providers

From: Matthew Upton, MD

Date: 9/16/2021

Subject: RE: MAB Clinic Relocation to SFH

The Monoclonal Antibody Therapy Clinic has been relocated to Saint Francis Hospital, on 4 East.

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.**

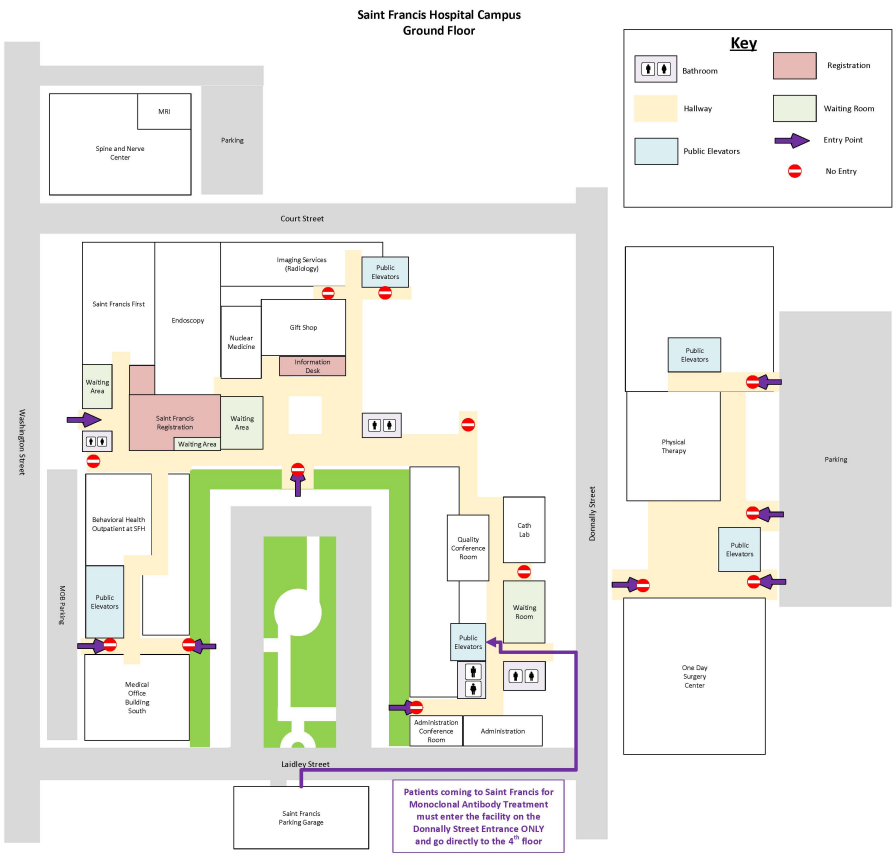
We will schedule them for an antibody infusion as quickly as possible. Patients are asked to wear a mask and **only** enter the facility at the Donnally Street Entrance of the hospital and immediately report to the 4th floor. Follow the signage to check-in, they will then be moved into the antibody clinic 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/

-- Matt
Matthew Upton, MD
Thomas Health – CMO/CMIO



Monoclonal Antibody Therapy Infusion Order and Criteria

Monoclonal antibody therapy should be reserved for patients 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 these criteria as resources change or as state/regulatory agencies deem appropriate.

☐ **COVID Positive adult and pediatric individuals who meet the criteria for high risk of progressing to severe COVID-19.**

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

☐ **Unvaccinated or not fully vaccinated adult and pediatric individuals who meet the criteria for high risk of progressing to severe COVID-19 and**

- who have been in close contact of individuals identified as COVID positive within the previous 4 days **or**
- who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of COVID-19 infection in other individuals in the same institutional setting (for example, nursing homes or prisons).

☐ **Vaccinated adult and pediatric individuals who are not expected to mount an adequate immune response** to complete SARS-CoV-2 vaccination (for example, individuals with immunocompromising conditions including those taking immunosuppressive medications) who meet the criteria for high risk of progressing to severe COVID-19 **and**

- who have been in close contact of individuals identified as COVID-19 positive within the previous 4 days **or**
- who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of COVID-19 infection in other individuals in the same institutional setting (for example, nursing homes or prisons).

Exclusion Criteria - May NOT have any of the following:

1. Patients hospitalized due to COVID-19
2. Patients requiring oxygen due to COVID-19 or an increase from baseline
3. Less than 12 years old
4. Less than 40kg
5. Greater than 10 days of symptoms

USE LABEL OR PRINT PATIENT ID HERE

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Monoclonal Antibody Therapy Infusion Order and Criteria

Need one of the following:

(Please check the appropriate criteria)

Inclusion Criteria (Individuals at high risk for severe progression of COVID-19)

- ☐ Older age (≥ 65 years of age)
- ☐ Obesity or being overweight (adults with BMI ≥ 25 kg/m2, or if age is 12-17, have BMI ≥ 85th percentile for their age and gender based on CDC growth charts

  Pt weight _____ Pt Height _____
- ☐ Pregnancy
- ☐ Diabetes
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Sickle Cell Disease
- ☐ Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- ☐ Chronic Kidney Disease
- ☐ Immunosuppressive disease or treatment
- ☐ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstital lung disease, cystic fibrosis, and pulmonary hypertension)
- ☐ Having medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)

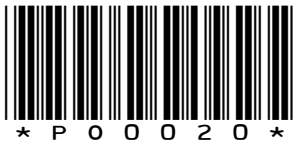
- ☐ Casirivimab/Imdevimab 1200mg IV piggyback once, infuse as per protocol. **OR**
- ☐ Bamlanivimab 700mg IV/ Etesevimab 1400mg piggyback once, infuse as per protocol.

MAB administration will be based on medication availability. Physician will be notified if ordered MAB is changed.

I attest that at the time of ordering, the patient meets the above-mentioned criteria for use under the EUA for Casirivimab/Imdevimab or Bamlanivimab/Etesevima.

Date:_____ **Time:**_____ **Physician Signature:**_____

USE LABEL OR PRINT PATIENT ID HERE



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COVID-19 MONOCLONAL ANTIBODY THERAPY

PLEASE FAX THIS FORM AND THE THOMAS HEALTH COVID-19 MONOCLONAL ANTIBODY INFUSION 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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