PRESBYTERIAN
Infusion Services

Provider Referral
COVID-19 Monoclonal Antibody Therapy
Referral Help Line: 505-563-1024

Patient

Name (Last, First)

DOB: Age:

Primary Language:

Provider

Name:

Phone:

Practice:

Address:

Availability and Locations for Monoclonal Antibody Therapy

NOTE: Not all regional sites may offer COVID-19 infusion services or may be limited to adults only. Please call site to confirm.

- Albuquerque 505-563-1024
- Santa Fe 505-772-1027
- Ruidoso 575-630-4243
- Clovis 575-769-7492
- Socorro 575-835-1140
- Tucumcari 575-461-7090
- Espanola 505-367-7257

Eligibility for Monoclonal Antibody Therapy

Presbyterian is providing monoclonal antibody therapies under FDA Emergency Use Authorization for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older; weighing at least 40 kg; and, who are at high risk for progressing to severe COVID-19 and/or hospitalization.

Monoclonal antibodies should be administered as soon as possible after positive SARS-CoV-2 (PCR or antigen testing) and **within 10 days of symptom onset**. Patients are not eligible for treatment if > 10 days from symptom onset.

Per FDA requirements, patients will be provided an FDA Fact Sheet for Patients, Parents and Caregivers prior to infusion therapy.

Patient Eligibility

Patient must meet **at least one High Risk criterion. Check all that apply.**

- ☐ Older age (for example ≥65 years of age)
- ☐ Obesity or overweight
  - ○ Adult: BMI ≥25
  - ○ Age 12-17: BMI ≥85th percentile for their age and gender based on CDC growth charts
- ☐ Pregnancy
- ☐ CKD
- ☐ Diabetes
- ☐ Immunosuppressive disease or immunosuppressive treatment
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Chronic lung disease Chronic (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary 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)
- ☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation [not related to COVID-19])
- ☐ Medical condition/factor conferring high risk for progression to severe COVID-19, such as race or ethnicity. Describe below.

COVID-19 Diagnosis and Testing Information

Date of Symptom(s) Onset: Date of 1st COVID-19 Positive Test Result in the past 90 days:

Testing Location Name: City: State:

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Patient Information
Name (Last, First)

Provider Information
Name (Last, First)

Provider Attestation and Signature

☐ **I attest the patient I am referring for therapy:**

- has a recent positive SARS-CoV-2 test result,
- is under my medical care and will follow up with me for any necessary COVID-19- related medical issues,
- has become symptomatic in the past 10 days (and can reasonably treated within 10 days of symptom onset)
- is ≥ 12 years of age,
- weighs ≥ 40 kg,
- has been informed (or parents/caregivers have been informed) of alternatives to receiving this medication,
- has been informed (or parents/caregivers have been informed) that the medication is an unapproved product permitted
- use under Emergency Use Authorization only,
- has been advised (or parents/caregivers have been advised) to report any suspected adverse drug events to this Infusion Center immediately for FDA reporting
- does NOT meet ANY of the following exclusionary criteria:
    - previously hospitalized due to COVID-19, OR
    - requires oxygen therapy due to COVID-19, OR
    - requires an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related co-morbidity

Provider Signature:
(Signature stamps not accepted, wet signature required)

Date:

Referral Submission Instructions

Please fax all the of the following, in one fax, to the **Presbyterian Infusion Center Fax (505) 563-1015**

Fax coversheet from referring provider primary practice

This Presbyterian Infusion Center Referral Form, fully complete, including wet signature of provider

Patient Demographics (Patient Name, DOB, Address, Insurance, Primary Language)

Copy of most recent clinical encounter (e.g. History and Physical, Progress Note, Telephone Note, Video Visit)

Copy of positive COVID-19 test result. If a copy of the test result is not available, list mitigating factors below.

Referring Provider Comments