COUNCIL OAK
COMPREHENSIVE HEALTHCARE

Casirivimab and Imdevimab – COVID Positive Referral Form (Dx: U07.1)

Patient Information

Name: _____ DOB: _____ Race: _____

Allergies:_____

Date of COVID-19 Symptom Onset _____ COVID-19 Positive Result Date _____

1) The infusion of therapy must occur within 10 days of symptom onset
2) Please include copy of COVID Positive Test Result.
3) Please provide Demographics and Insurance Payor (Please provide copy of insurance card)

Patient Eligibility

Exclusion Criteria (Patients meeting any of the following criteria are **NOT ELIGIBLE** for Casirivimab and Imdevimab therapy)

a. who are hospitalized due to COVID-19
b. who require oxygen therapy due to COVID-19
c. who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

Inclusion Criteria: (at least one of the following criteria must be met to qualify) *****CHECK ALL THAT APPLY**:***

Patient Weight: _____ lbs _____ kg Patient Height: _____ in Date: _____
****Patient 12-17 years of age or older must weigh at least 40 kg (88 lbs)

Patient must have at least one of the following (***select all that apply***):

☐ Body Mass Index (BMI) according to age: _____
****Obesity or being overweight (for example, BMI >25 kg/m2 , or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)

☐ Chronic Kidney Disease
☐ Diabetes
☐ Pregnancy
☐ Sickle Cell Disease
☐ ≥ 65 years of age
☐ Immunosuppressive Disease or treatment
☐ Neurodevelopmental disorders
☐ Medical-related technological dependence
☐ Chronic lung disease
☐ Cardiovascular disease

*******By signing this order, physician verifies that the patient meets eligibility criteria*******

Prescriber Name: _____
Prescriber Signature: _____
Date:_____
Supervising Physician (if APRN or PA): _____

Return Completed Form to: (918)216-8093

COUNCIL OAK
COMPREHENSIVE HEALTHCARE

Casirivimab and Imdevimab - Post Exposure Prophylaxis Referral Form (Dx: Z20.828)

Patient Information

Name: _____DOB: _____ Gender:__M / F___

Address: _____ City:_____ State:_____

Height (in): _____ Weight: _____ (lbs) _____ (kg)

Allergies:_____

Date of suspected exposure (***must be within 10 days of treatment***):_____
Please provide a copy of demographics and copy of insurance payer

Patient Eligibility

Exclusion Criteria: Patients meeting any of the following criteria are **NOT ELIGIBLE** for Casirivimab and Imdevimab

a) Post-exposure prophylaxis with REGEN-COV (casirivimab and imdevimab) is not a substitute for vaccination against COVID-19.
b) REGEN-COV (casirivimab and imdevimab) is not authorized for pre-exposure prophylaxis for prevention of COVID-19.

Inclusion Criteria: (at least one of the following criteria must be met to qualify for Casirivimab and Imdevimab post exposure prophylaxis) *****CHECK ALL THAT APPLY**:***

1) Patients must not be fully vaccinated or 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) **AND**
   - ☐ Have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per Centers for Disease Control and Prevention (CDC) **OR**
   - ☐Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, nursing homes, prisons)

2) **AND** be at high risk for progression to severe COVID-19, including hospitalization or death. Patient must have at least one of the following (***select all that apply***):
   - ☐ Body Mass Index (BMI) according to age: _____
   ****Obesity or being overweight (for example, BMI >25 kg/m2 , or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)

   - ☐ Chronic Kidney Disease
   - ☐ Diabetes
   - ☐ Pregnancy
   - ☐ Sickle Cell Disease
   - ☐ ≥ 65 years of age
   - ☐ Immunosuppressive Disease or treatment
   - ☐ Neurodevelopmental disorders
   - ☐ Medical-related technological dependence
   - ☐ Chronic lung disease
   - ☐ Cardiovascular disease

*******By signing this order, physician verifies that the patient meets eligibility criteria*******

Prescriber Name: _____
Prescriber Signature: _____
Date:_____
Supervising Physician (if APRN or PA): _____

Return Completed Form to: (918)216-8093