**Sotrovimab – COVID Positive Referral Form (Dx: U07.1)**

## Patient Information

Name: ________________________ DOB: ________________________ Race: ________________________

Allergies: ____________________________________________________Phone: ______________________________

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 Sotrovimab 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: _______________

Body Mass Index (BMI) according to age: __________
****Patient 12-17 years of age or older must weigh at least 40 kg (88 lbs)

Risk stratification will be used to determine highest need for treatment based on NIH Risk Group Prioritization tool, please ***select all that apply***:

- ☐ 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
- ☐ Unvaccinated or not fully vaccinated
- ☐ Obesity or being overweight (for example, BMI >30 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)

*****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