HAYAT PHARMACY

Fax: 414-238-0187
Phone: 414-269-2530

Monoclonal Antibody Treatment Referral Form

Date: _____

I am referring my patient _____ (first name, last name) _____ (DOB) **for monoclonal antibody (casirivimab and imdevimab administered to subcutaneously to aid in the management of your mild to moderate COVID-19 disease because patient is at high-risk of progressing to severe COVID-19 disease that may require your admission to a hospital. My patient (age 12-17 years and weighing at least 40 kg) qualifies based on the following risk factors and are at higher risk for progression to severe COVID-19:**

- Older age (for example, age ≥65 years of 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)
- Pregnancy
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension
- Chronic lung diseases (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).

Patient Name _____ **Sex: M F**

Address _____ **City** _____

State _____ **Zip** _____ **Phone Number** _____

Birth Date _____/_____/_____

Allergies _____

_____

Referring Provider _____

Provider Phone _____