MONOCLONAL ANTIBODY
Referral Form

Hy-Vee health

Patient Information

Last Name	First Name	DOB
Gender	Social Security #	Primary Language
Address		
City	State	ZIP
Allergies		
Phone	Height	Weight
Symptom Onset Date and Time of Day	COVID-19 Positive Date	

Prescriber Information

Name of Contact Sending Referral		Title
Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax		Referral Contact Email
Office Phone		Office Fax
Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name/Specialty		

Insurance Information

Insurance Provider	Plan ID #	Eligible for Medicare (check one) ☐ Yes ☐ No	List Red, White & Blue Card #
Insured's Name	Relationship to Patient	If no insurance, list driver's license number and state of issue	

Please fax with order form: Current Medication List & Copy of Insurance Card

Eligibility

Exclusion Criteria: If patient meets any of the following, they are not eligible for treatment:
- Hospitalized due to COVID-19.
- Require oxygen therapy due to COVID-19.
- Require an increase in baseline oxygen flow due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity.

Inclusion Criteria: Patients must be >=12 years old (Age:) AND weigh >=40kg (Wt kg) AND be at high risk for progressing to severe COVID-19 or hospitalization.

• Factors which place this patient at higher risk (check all that apply) •

- ☐ Older age (i.e, >= 65 Years old
- ☐ Overweight/obese (i.e., BMI>25 or pediatrics >85th%)
- ☐ Pregnancy
- ☐ Chronic Kidney Disease
- ☐ Diabetes
- ☐ Immunosuppressive Disease or Treatment
- ☐ Chronic Lung Disease
- ☐ Sickle Cell Disease
- ☐ Cardiovascular Disease or Hypertension
- ☐ Medical-Related Technological Dependence (for example tracheostomy, gastrostomy or positive pressure ventilation (unrelated to COVID-19))
- ☐ Neurodevelopmental Disorders (e.g., cerebal palsy) or other conditions that confer medical complexity (e.g., genetic or metabolic syndromes and severe congenital anomalies)
- ☐ Other (please specify)

Medication Orders

- ☒ ***Bebtelovimab:** 175 mg/2 ml IVP: Directions: Must be given in 7 days from onset of symptoms.
- ☒ **Flush line with D5W:** 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Amber Specialty Pharmacy protocol.
- ☒ **Anaphylaxis Kit:** per Hy-Vee Health anaphylaxis treatment protocol.

Indicate IV access type:

Peripheral: PICC: Port:

Indicate vaccination status:

☐ Unvaccinated ☐ Partially Vaccinated ☐ Fully Vaccinated ☐ Boosted

Nursing Orders

RN to insert peripheral IV or access existing central catheter.
RN to observe patient for one hour post-infusion.
RN to complete patient assessment.

Phone: 515.225.2930
Fax: 515.559.2495

Prescriber Signature _____ Date _____

Please Print Name _____ NPI _____