COVID INFUSION CENTER

A Division of Wilson Medical

COVID-19 Monoclonal Antibody Order Form

Please fax form to: 405-265-2926

Patient Information

Patient Name:	DOB:	Phone:	Gender: M ☐ F ☐
Patient Address:	Email:	Insurance:	

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax COVID + test results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ Code: _____ Description: SARS-CoV-2 Positive / (COVID-19)

Clinical Information:

☐ Patient Weight: _____ lbs / _____ kg ☐ Patient Height: _____ in / _____ cm
☐ Allergies: _____
☐ Date of SARS-CoV-2 Positive Test: _____ ☐ Date of Symptom Onset: _____

Patients ≥ 18 years who have one of the following:

☐ BMI ≥ 35
☐ Chronic kidney disease
☐ Diabetes
☐ Immunosuppressive disease
☐ Receiving immunosuppressive treatment
☐ Age ≥ 65 years
☐ Age ≥ 55 years AND have one of the following:
  ☐ Cardiovascular disease
  ☐ Hypertension
  ☐ COPD/other chronic respiratory disease

Patients 12-17 years AND have one of the following:

☐ BMI ≥ 85th percentile for age/gender, OR
☐ Sickle cell disease, OR
☐ Congenital or acquired heart disease, OR
☐ Neurodevelopmental disorder, OR
☐ Medical-related technological dependence, OR
☐ Asthma, reactive airway, or chronic respiratory disease that requires daily medication

Prescription Information

☐ Casirivimab and Imdevimab	☐ Dose: 600mg Casirivimab and 600mg Imdevimab *Note: Prescriber authorizes Bamlanivimab if Casirivimab and Imdevimab not available.*
☐	☐

Pre-Medication Orders

☒ Dexamethasone10mg SIVP ☒ Benadryl 25mg PO PRN
☒ Tylenol tablet 500-1000mg PO PRN ☐ Other: _____

Standing Orders for Adverse Reactions

☒ Stop infusion and initiate NS bolus ☒ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☒ Notify supervising physician and ordering provider ☒ Oxygen 2-5L nasal cannula
☒ Dexamethasone10mg SIVP signs of adverse reaction ☒ Albuterol 2.5mg inhaled PRN for chest tightness
☒ Benadryl 25mg SIVP for hives or bronchial inflammation ☐ Other: _____

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

_____ _____
Prescriber's Signature: **Date:**

By signing this form, you are authorizing COVID Infusion Center and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form to: 405-265-2926

Yukon Location 1728 Professional Circle, Yukon, OK 73099 Phone:405-265-2733