CourMed
Concierge Healthcare & Wellness

6800 Weiskopf Ave. Ste. 150
McKinney, TX 75050
Toll-free: (833) 268-7633
Fax: (469) 217-9027
Email: admin@courmed.com

Home Infusion COVID Monoclonal Antibody Order

Date/Time: _____

Patient Name: _____ DOB: _____ Patient

Gender: _____ Address: _____ Phone:

_____ Caretaker Name/Phone: _____ Known

Allergies: _____

All sections MUST BE COMPLETED, or patient will not receive therapy

REQUIRED CRITERIA

☐ **MUST PROVIDE POSITIVE TEST RESULT FOR COVID-19**

☐ **Date of CONFIRMED COVID POSITIVE TEST**: _____

☐ **Date of symptom onset: _____** (*Therapy can only be given within **7 days** of symptom onset.)* ☐ Age ≥ 12 years **AND** weight ≥ to 40Kg

☐ Patient is (1) **NOT** hospitalized due to COVID infection, (2) **NOT** requiring oxygen therapy due to COVID infection or **NOT** requiring more oxygen intake due to COVID infection than patient's normal baseline need

Must have at least one of the following criteria (check all that apply and please provide details where applicable)

☐Age ≥ 65 years

☐BMI > 25 (for patient 18 years old or older), or BMI ≥ to 85th percentile for their age and gender for patients 12 – 17 years old.

☐Hypertension

☐Diabetes

☐Chronic Kidney Disease ☐Sickle cell disease

☐Pregnancy

☐ Immunosuppressive disease, immunocompromised, or receiving immunosuppressive therapy. Please specify: _____

☐Cardiovascular disease (including congenital heart disease). Please specify: _____ ☐Chronic lung diseases, including COPD, asthma (moderate to severe), interstitial lung disease, cystic fibrosis, and pulmonary hypertension. Please specify: _____

☐Neuro-developmental disorder *(example: cerebral palsy)* or other conditions that confer medical complexity *(examples: genetic or metabolic syndromes and severe congenital anomalies)*. Please specify: _____

☐Having a medical-related technological dependence *(examples: tracheostomy, gastrostomy, or positive pressure ventilation **NOT** related to COVID 19)*. Please specify: _____

I, the provider, attest that I have done all the items listed below:

1. Provided the patient with the monoclonal antibody for COVID-19 Fact Sheet for Patients, Parents, and Caregivers.
   Bebtelovimab Patient Fact Sheet available at:
   - English: https://www.fda.gov/media/156153/download
   - Spanish: https://www.fda.gov/media/156155/download
2. Patient has been informed that COVID therapeutic are unapproved drugs that are authorized for use under FDA Emergency Use Authorization.
3. Patient expressed verbal understanding of all the information and agreed to proceed with monoclonal antibody therapy.

THERAPY

☐ **Bebtelovimab 175mg IV over at least 30 seconds ONCE**

Practice Name/Address: _____

Prescriber NPI: _____ Physician Phone (cell): _____ Physician

Signature: _____ Physician Name (print): _____

Therapy may be delayed if Pharmacy/Nurse unable to contact the physician

FAX the completed, signed, and dated ORDER FORMS to CourMed at (469) 217-9027

Please include **PATIENT DEMOGRAPHIC, INSURANCE, & a CURRENT MEDICATION LIST if available.**