

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**

Patient Name:	Date/Time:	•	
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  2 12 years AND weight 2 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 2 65 years  BMI> 25 (for patient 18 years old or older), or BMI 2 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 disease, immunocompromised, or receiving immunosuppressive disease, inmunocompromised, or receiving immunosuppressive disease, including congenital heart disease). Please  1. 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:  1. Provider the patient informed that COVID therapeutic are unapproved drugs that are authorized for use under FDA Emergency Use Authorization.  3. 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	Patient Name:	DOB:	Patient
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:	Gender: Address:	P	hone:
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 □ 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 □ Cardiovascular disease (including congenital heart disease). Please  1. Provided the patient with the monoclonal antibody for COVID-19 Fact Sheet for Patients, Parents, and Caregivers.  Bebtelovimab Patient Fact Sheet available at:  1. Provided the patient with the monoclonal antibody for COVID-19 Fact Sheet for Patients, Parents, and Caregivers.  Bebtelowimab Patient Fact Sheet available at:  2. Patient has been informed that COVID therapeuticare 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	Caretaker Name/Phone:		Known
REQUIRED CRITERIA    MUST PROVIDE POSITIVE TEST RESULT FOR COVID-19   Date of CONFIRMED COVID POSITIVE TEST:	Allergies:		_
Date of SONFIRMED COVID POSITIVE TEST:			
Date of symptom onset:	☐ MUST PROVIDE POSITIVE TEST RESULT FOR COVID-19		
≥ 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	☐ Date of CONFIRMED COVID POSITIVE TEST:		
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Age ≥ 65 years   Specify:   Chronic lung diseases, including COPD asthma (moderate to severe), interstitial lung diseases, cystic fibrosis and pulmonary hypertension. Please specify:   Shewro-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 NOI related to COVID 19). Please specify:   Having a medical-related technological dependence (examples: tracheostomy, gastrostomy, or positive pressure ventilation NOI related to COVID 19). Please specify:   Having a medical-related technological dependence (examples: tracheostomy, gastrostomy, or positive pressure ventilation NOI related to COVID 19). Please specify:   Having a medical-related technological dependence (examples: tracheostomy, gastrostomy, or positive pressure ventilation NOI related to COVID 19). Please specify:   Having a medical-related technological dependence (examples: tracheostomy, gastrostomy, or positive pressure ventilation NOI related to COVID 19). Please specify:   Provided the patient with the monoclonal antibody for COVID-19 Fact Sheet for Patients, Parents, and Caregivers.    1. the provider, attest that I have done all the items listed below:   Provided the patient with the monoclonal antibody for COVID-19 Fact Sheet for Patients, Parents, and Caregivers.    2. Patient has been informed that COVID therapeutic are unapproved drugs that are authorized for use under FDA Emergency Use Authorization.   Authorization	requiring more oxygen intake due to COVID infection than patien	nt's normal baseline need	
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Neuro-developmental disorder (example: cerebral palsy) or other conditions that confer medical complexity (examples: genetic or metabolic syndromes and severe congenital anomalies). Please specify:			-
Chronic Kidney Disease   Sickle cell disease   Chronic Kidney Disease			
Chronic Kidney Disease   Sickle cell disease   Section   Section	• •		
Pregnancy			-
Immunosuppressive disease, immunocompromised, or receiving immunosuppressive therapy. Please specify:	•	specify:	
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Prescriber NPI: Physician Phone (cell): Physician	Practice Name/Address:		
	Prescriber NPI: Ph	nysician Phone (cell):	Physiciar

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.