 Date:

 **REGEN-COV/SOTROVIMAB/CASIRIVIMAB & IMDEVIMAB**

**Infusion Order Form**

Patient Name: DOB:

Provider Name: Fax Number:

Date of First Symptoms: Date of Positive COVID Test Result:

Symptoms:

COVID Vaccine: [ ]  yes [ ]  no [ ]  Moderna [ ]  Pfizer [ ]  J and J

 [ ]  1st dose: [ ]  2nd dose: [ ]  booster:

 date date date

[ ]  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 chart, <http://www.dcd.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, COPD, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis, and/or 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 dependance (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))

[ ]  This patient is at high risk for complications of COVID including death and permanent disability and mAb is currently the most effective treatment available, therefore after a risk-benefit discussion, I have elected to proceed with mAb.

**Consent for service:** I have been provided with REGEN-COV or SOTROVIMAB EUA that corresponds to the infusion I am receiving. I have read the information provided about the infusion I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of infusion and I voluntarily assume full responsibility for any reactions that may result. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the infusion be given to me or to the person named above for whom I am authorized to make this request.

**Authorization to request payment:** I do hereby authorize Pickens County Primary Care, PC to release information and request payment. I certify that the information given by me in applying for the payment under Medicare or Medicaid is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

**Disclosure of records:**  I understand that Pickens County Primary Care, PC may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people receiving infusions at PC3 (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems, and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations, (such as administration of quality assurance). I also understand that PC3 will use and disclose my information as set forth in the PC3 Notice of Privacy Practices (copy is available upon request). **Infusion Clinics: If I am receiving an infusion through an infusion clinic, I understand that my name and infusion appointment date and time will be provided to the clinic coordinator.**

 Patient Signature Date

**Please select which mAb infusion you would like the patient to receive:**

[ ]  REGEN-COV [ ]  SOTROVIMAB [ ]  CASIRIVIMAB & IMDEVIMAB

**Is it ok to substitute for above mAb preference checked?**  Provider Signature

[ ]  YES [ ]  NO