Maryland
DEPARTMENT OF HEALTH

Maryland Referral Form
Ambulatory Monoclonal Antibody Infusion Treatment for COVID-19

If your patient could benefit from monoclonal antibody treatment, please complete the information below. This form should be sent to the infusion site with closest proximity to the patient and follow the referral process as noted below according to the appropriate site. The Infusion Site will review the referral form upon receipt and contact the patient to coordinate services as soon as possible.

Region 1: UPMC Western Maryland Hospital	Email form to WMD-COVIDantibody@upmc.edu
Region 2: Meritus Regional Infusion Center	Fax form to 301-790-9229
Region 3: Baltimore Convention Center Field Hospital	Go to umms.org/ICReferral to submit form via secure, HIPAA-compliant upload.
Region 4: TidalHealth Peninsula Regional	Email form to COVIDTX@TidalHealth.org or Fax: 410-912-4959
Region 4: Atlantic General Hospital	Fax form to 410-641-9708
Region 5: Adventist HealthCare Takoma Park Alternative Care Site Infusion Center	Fax form to 301-891-6120

**First Name: ** Last Name:

**DOB: Age:

**Sex: ☐ M ☐ F ☐ Other _____ ☐ Unknown

**Patient's Preferred Language ☐ English ☐ Spanish ☐ Other _____

**Address Line 1:

Address Line 2:

City: State: County: **Zip:

County:

**Phone: ☐ cell ☐ home Secondary Phone: ☐ cell ☐ home

Allergies (medication/food/other):

Please include any additional historical patient health information. You may free text, copy/paste, or you may attach a recent clinic note or other documentation, as necessary.

The (**) indicates a required field.

**Weight (lbs): Kg: **Height (feet/inches): BMI:

**Patient has had a recent SARS-CoV2 PCR or Rapid Antigen Positive Test Result: □ Yes □ No
Note: Test must be first known positive test result.

** SARS-CoV2 PCR or Rapid Antigen test date (date specimen was obtained): _____

****SARS-CoV2 symptom onset date (best approximation)**: _____

**Patient Symptoms (check all that apply):
□ Fever □ Cough □ SOB □ Loss of taste/smell □ Malaise/Fatigue
□ Nausea/Vomiting □ Diarrhea □ Throat pain □ Congestion □ Myalgia
□ Headache □ Other _____

SpO2: ____ (If < 94%, patient should be referred for hospitalization due to need for supplemental O2 and thus would not be appropriate for monoclonal antibody treatment.)

□ On RA or □ On chronic O2 therapy – Baseline O2 Flow rate: _____

Has the patient required an increase in O2 flow rate since becoming symptomatic with COVID? □ Yes □ No

*****High Risk for Severe COVID Illness (check all that apply, continued on page three):***
□ Age ≥ 65 y/o □ BMI ≥ 35 □ Diabetes Mellitus □ Type II □Type I
□ CKD Disease Stage ____ Baseline [Cr]____
□ Immunosuppressive Disease (e.g. leukemia, lymphoma, asplenia, neutropenia, AIDS if CD4 < 200, etc.) / Specify: _____
□ Immunosuppressive Treatment (e.g. chronic steroid, chemotherapeutic, biologic immunomodulator) / Specify: _____

□ Age ≥ 55 y/o *and:*
□ Cardiovascular Disease / Specify (e.g. CAD, CVD, PVD, cardiomyopathy): _____
□ HTN
□ COPD
□ Other Chronic Respiratory Disease (e.g. Pulmonary Sarcoid, Pulmonary Fibrosis) / Specify: _____

□ Age 12 – 17 y/o *and:*
□ BMI ≥85th percentile for their age and gender based on CDC growth charts
□ Sickle Cell Disease
□ Congenital or acquired heart disease / Specify: _____
□ Neurodevelopmental Disorder (e.g. cerebral palsy, muscular dystrophy) / Specify: _____
□ Medical-related technological dependence (e.g. trach, g-tube dependence, shunt dependence, chronic infusion dependence) / Specify: _____
□ Asthma/Reactive Airway Disease/Chronic Respiratory Disease Requiring daily medication for control / Specify: _____

The (**) indicates a required field.

I, the referring provider, am the patient's PCP or other continuity provider and have arranged for the patient to follow up with me/my designee following Antibody infusion. Or I am an ED or Urgent Care provider who will update the patient's PCP about his/her Antibody infusion in order to arrange follow up. If the patient does not have a PCP, I will refer him/her to an appropriate provider and ensure that follow up has been arranged. [Note: Ideal timing of follow up visit is approximately 7 days post-infusion.]
☐ **Indicates Provider Agreement

I, the referring provider, have advised or will advise the patient that if his/her clinical status declines by the time of the infusion appointment, the treatment may no longer be appropriate for him/her. The patient's clinical status will be re-evaluated at the infusion center at the appointment time. If the patient is deemed in need of hospital care, s/he will be referred immediately.
☐ **Indicates Provider Agreement

**** Please provide the following information:**

☐ If patient meets the above criteria give bamlanivimab 700 mg IV times 1 dose over 60 minutes OR Casirivimab 1200 mg/Imdevimab 1200 mg IV times 1 dose over 60 minutes (depending on supply/infusion site protocol).

Provider Signature_____ Date_____

The Infusion Center staff will communicate with the referring provider regarding such matters as treatment inappropriateness for patient, ultimate completion of treatment for patient, adverse events, etc.

Name of Referring Site:	Point of Contact:
Address:	
Phone Number:	Fax Number:
Email address:	Preferred mode of contact: ☐ Phone ☐ Fax ☐ Email

Patient's Primary/Continuity Care Provider (if different from above)

Office Name:	
Address:	Phone Number:
Email address:	Fax Number:

There are two Antibody treatments on our formulary. Patients will be scheduled for one or the other treatment based on availability of medications and logistics.

Information about both monoclonal antibody medications, including Fact Sheets and Manufacturer Instructions/Package Inserts for Healthcare Providers and for Patients/Parents/Care Givers, can be found at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization#coviddrugs (scroll to section on Drugs and Biologic Products).

The (**) indicates a required field.