KING'S DAUGHTERS

# Documentation for Monoclonal Antibody Therapy for COVID-19

Instructions for Provider: Complete all portions of this form. Missing information could lead to delays in treatment. Fax this form, along with the prescription and patient demographic sheet to King's Daughters Infusion Center at **(606) 408-6724**.

Ordering Provider: _____ Date: _____

Ordering Provider's Phone: _____ FAX: _____

Patient's Name: _____ DOB: _____ Age: _____

☐ Discussed with patient/caregiver that the patient meets the criteria for treatment with monoclonal antibodies for mild-to-moderate COVID-19 based upon age. *King's Daughters is not authorized to provide this therapy to patients ≤18.* Monoclonal antibodies will be administered based on availability, per King's Daughters Pharmacy Protocols.

☐ Qualifying co-morbidities **REQUIRED**: _____

_____ **BMI:** _____

Estimated date of symptom onset: _____ The patient reports the following symptoms:

☐ Fever or chills
☐ Cough
☐ Difficulty breathing
☐ Fatigue
☐ Muscle or body aches
☐ Headache
☐ New loss of taste or smell
☐ Sore throat
☐ Congestion or runny nose
☐ Nausea or vomiting
☐ Diarrhea
☐ Other: _____

☐ This patient/caregiver was directed to the online monoclonal antibody fact sheet; was informed that monoclonal antibodies are an unapproved drug that has received Emergency Use Authorization (EUA) from the U.S. Food & Drug Administration; was informed of the potential risks and benefits of such therapy; and was informed of alternative treatments.

☐ The patient has been informed of and understands the need for them to self-isolate and follow infection prevention/control measures according to U.S. Centers for Disease Control guidelines.

**OXYGEN USE**

☐ The patient **<u>was not on oxygen</u>** at baseline and did not require oxygen at the time of this clinical evaluation.

☐ The patient **<u>was on oxygen</u>** at baseline and did require oxygen at the time of this clinical evaluation.
Baseline $O^2$: _____ $O^2$ flow, liters per minute: _____

Date of Positive COVID-19 Test: _____
*If testing was not performed by King's Daughters, include a copy of the positive test results with this documentation.*

**PATIENT'S VACCINATION STATUS:** ☐ Full ☐ Partial ☐ Unvaccinated

**PROVIDER SIGNATURE:** _____ **DEA #:** _____

EB 09/21