COUNCIL OAK
COMPREHENSIVE HEALTHCARE

Casirivimab and Imdevimab - Post Exposure Prophylaxis Referral Form (Dx: Z20.828)

Patient Information

Name: ________________________________DOB: _________________ Gender:__M / F___

Address: ________________ City:__________________ State:____________

Height (in): ____________________ Weight: ______________ (lbs) _____________ (kg)

Allergies:_______________

Date of suspected exposure (***must be within 10 days of treatment***):___________
Please provide a copy of demographics and copy of insurance payer

Patient Eligibility

Exclusion Criteria: Patients meeting any of the following criteria are **NOT ELIGIBLE** for Casirivimab and Imdevimab

a) Post-exposure prophylaxis with REGEN-COV (casirivimab and imdevimab) is not a substitute for vaccination against COVID-19.
b) REGEN-COV (casirivimab and imdevimab) is not authorized for pre-exposure prophylaxis for prevention of COVID-19.

Inclusion Criteria: (at least one of the following criteria must be met to qualify for Casirivimab and Imdevimab post exposure prophylaxis) ***__CHECK ALL THAT APPLY__*****:**

1) Patients must not be fully vaccinated or not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination (for example, individuals with immunocompromising conditions including those taking immunosuppressive medications) **AND**
   - ☐ Have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per Centers for Disease Control and Prevention (CDC) **OR**
   - ☐Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, nursing homes, prisons)

2) **__AND__** be at high risk for progression to severe COVID-19, including hospitalization or death. Patient must have at least one of the following (***__select all that apply__***):
   - ☐ Body Mass Index (BMI) according to 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 charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)

- ☐ Chronic Kidney Disease
- ☐ Diabetes
- ☐ Pregnancy
- ☐ Sickle Cell Disease
- ☐ ≥ 65 years of age
- ☐ Immunosuppressive Disease or treatment
- ☐ Neurodevelopmental disorders
- ☐ Medical-related technological dependence
- ☐ Chronic lung disease
- ☐ Cardiovascular disease

*******By signing this order, physician verifies that the patient meets eligibility criteria*******

Prescriber Name: ___________________________________
Prescriber Signature: ________________________________
Date:____
Supervising Physician (if APRN or PA): ____________________________

Return Completed Form to: (918)216-8093