SIGNATURE HEALTHCARE
680 Centre Street, Brockton, MA 02302

COVID-19 Monoclonal Antibody EUA Treatment Intake Form

Patient Information

Name:_____ **Date of Birth:**_____ **Sex: M / F / X**

Address:_____

Phone:_____

Allergies:_____ **Weight:**_____

Due to the severely limited supply and extremely high demand for monoclonal antibody, criteria for getting this treatment has been limited to only those listed below.

This is based on the NIH's recommendations that when supply constraints exist, monoclonal antibody treatments should be prioritized to those at highest risk of clinical progression.

Treatment Criteria for Use (all fields must be completed to refer patient for treatment)

- ☐ **Date of symptom onset:**_____ *Per EUA criteria, treatment must be given with 10 days of symptom onset.*
- ☐ **Symptoms:**_____
- ☐ **Date of positive COVID-19 test:**_____
- ☐ **Treatment-qualifying high-risk condition(s)** present: (check all that apply, **must** have at least one of these)
  - ☐ Unvaccinated age 65 or older
  - ☐ Unvaccinated age 55-65 or with diabetes or BMI > 35
  - ☐ Age 18 and over with moderate to severe immunocompromised state due to medications such as chemotherapy, biologics, immunosuppressants
  - ☐ Age 18 and over with moderate to severe immunocompromised disease such as IgG deficiency, Severe Combined immunodeficiency, etc.

    Name of qualifying condition:_____

Prescriber Attestation (must be checked to be eligible for treatment)

☐ I affirm that my patient meets above criteria for use and that patient agrees to referral for mAb treatment.

Provider Name (Print):_____ Provider Contact Number:_____ Ext:_____

Provider Signature/Title:_____ Date:_____

Fax this form and a list of medical problems and medications (with patient name & DOB) to **508-894-0443.**