

Monoclonal Antibody Treatment



By completing this form, your patient will be included in the randomized selection process that Mount Nittany Health is using to determine who will receive monoclonal antibody treatment. Possible regimens include Bamlanivimab and casirivimab/imdevimab based on current supply. Completion of the form does not guarantee that your patient will receive the antibody treatment.

Once form is complete, please send to CovidCare@mountnittany.org If you have questions, you may call 814-231-7899 and a member of our clinical team will return your call.

Please indicate what criteria your patient meets below. Based on those responses, it will be determined if your patient meets all of the criteria for treatment. Patients are only considered eligible for treatment if they are 7 days from symptom onset or if asymptomatic, 7 days from testing date. Patients may be excluded based on days of eligibility, weight (<40 kg), oxygen flow increase, or hospitalization associated with COVID-19. Thank you for referring your patient into this program.

Patient Information

Last Name: _____ Gender: ___M___F___U

First Name: _____ Phone Number: _____

DOB: _____ Age: _____ Weight: _____ BMI: _____

Date of Collection for COVID-19 Testing

- Was the patient symptomatic? Y/N
 - If yes, what symptoms did they have?
 - If yes, what date did they become symptomatic?
- Is the patient aware of their positive COVID-19 test results? Y/N
- Has the patient been hospitalized for this instance of COVID-19? Y/N
- Is the patient on home oxygen therapy? Y/N
 - If yes, has there been an increase to their oxygen liter flow related to this COVID-19 illness?
- Does the patient have any allergies to Histidine, L Histidine, or PolySorbate 80? (Circle which choice applies) Y/N

Circle which criteria your patient meets

- 65 years and older
- BMI \geq 35
- CKD
- Diabetes
- Immunosuppressive state
- Currently receiving immunosuppressive treatment
- Age >55 AND one of the following
 - CVD
 - HTN
 - COPD
 - Chronic Respiratory Disease
- Age 12-17 AND one of the following
 - BMI > 85th percentile for their age and gender based on CDC growth chart
 - Sickle cell disease
 - Congenital or acquired heart disease
 - Neurodevelopment disorders (CP)
 - Medical technological dependence (tracheostomy, gastrostomy, positive press ventilation-not related to COVID)
 - Asthma, reactive airway disease or other chronic respiratory disease that requires daily medication for control

Referred by (Print Name): _____ Date: _____

Provider Phone Number: _____ Fax Number: _____

For Internal Use Only

Patient met criteria: Yes No

Patient Accepted Treatment: Yes No

Patient Declined Treatment: Yes No

Patient Did Not Answer: Yes No

Patient Appointment Date if Applicable: _____

Date: _____ Nurse initials: _____