866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

IV MAB

Send your RX to:

Date Medication Needed: ______________________________

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical)

Patient Name: ______________________ Birth Date: ____________ Gender: ☐ Male ☐ Female

Height: ____________ Weight: ____________ ☐ lbs. ☐ kg.

SS#: ________________ Preferred Phone: _____________ Known Allergies: ________________

Address: __________________ City: __________________ State: ________ ZIP: __________

Insurance Info: _________________________ Policy Number: __________________________

2. PRESCRIBER INFORMATION

Provider Name: ______________________ DEA#: _______ NPI#: ________ TAX ID#: ________

Address: ________________________ Phone: _________________ Fax: _________________

City, State, ZIP: ____________________ Key Contact: _____________ Phone #: _____________

3. CLINICAL INFORMATION

Patient Eligibility

Exclusion Criteria (Patients meeting any of the following criteria are **NOT ELIGIBLE** for therapy)

a. Hospitalized due to COVID-19

b. Require oxygen therapy due to COVID-19

c. Require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

By signing this order, physician verifies that none of the above criteria apply.

Check all that apply:

Covid-19 Test Positive: ☐ Yes ☐ No

Date of test: ____________

Date symptoms started: ____________

INDICATION:

1. Treatment of mild to moderate COVID-19 patients (check all that apply)
   - Age is > or equal 12 years old: ☐ Yes ☐ No
   - Patient has positive covid test: ☐ Yes ☐ No
   - Patient weighs at least 40kg: ☐ Yes ☐ No

INDICATION (Cont):

- At high risk for developing severe Covid 19 symptoms or hospitalization or death: ☐ Yes ☐ No
  - High risk criteria as any of the following (Check all that apply)
    - ☐ Older age (e.g. ≥65 years of age)
    - ☐ Overweight (e.g. BMI >25 kg/m2)
    - ☐ Pregnancy
    - ☐ Chronic kidney disease
    - ☐ Diabetes
    - ☐ Immunosuppressive disease or immunosuppressive treatment
    - ☐ Cardiovascular disease (e.g. congenital heart disease or hypertension)
    - ☐ Asthma
    - ☐ COPD
    - ☐ Interstitial lung disease (moderate-severe)
    - ☐ Cystic fibrosis and/or pulmonary hypertension
    - ☐ Sickle cell disease
    - ☐ Neurodevelopmental disorders (e.g. cerebral palsy)
    - ☐ Genetic or metabolic syndromes
    - ☐ Severe congenital anomalies
    - ☐ Having a medical-related technological dependence (e.g. tracheostomy, gastrostomy, or positive pressure ventilation not COVID 19 related
    - ☐ Race/ethnicity (per provider discern)

2. Post exposure prophylaxis (check all that apply)
   - ☐ Patient is not fully vaccinated
   - ☐ Patient is immune compromised
   - ☐ Patient is on immune suppressant medication
   - ☐ Patient have been exposed to positive covid-19 individual and consistent with close contact

4. PRESCRIPTION INFORMATION

Dosage/Route of administration:

☐ 600 mg of casirivimab and 600 mg of imdevimab administered together as a single intravenous infusion via IV pump or gravity (preferred route)

☐ 600 mg of casirivimab and 600 mg of imdevimab administered together as a subcutaneous injection

☐ 300 mg of casirivimab and 300 mg of imdevimab by subcutaneous injection OR intravenous infusion once every 4 weeks for the duration of ongoing exposure

OR

☐ 700mg of Bamlanivimab and 1400mg of Etesevimab administered together as a single intravenous infusion via IV pump

6. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

________________	__________	________________	__________
Dispense as written	Date	Substitution Permissable	Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner.
Prescribers are reminded patients may choose any pharmacy of their choice.

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