



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

Bamlanivimab Referral Form

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. PRESCRIPTION INFORMATION

Patient Eligibility

Exclusion Criteria (Patients meeting any of the following criteria are **NOT ELIGIBLE** for bamlanivimab 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 (replace letters with check boxes):

Covid-19 Test Positive: Yes No Date of test: _____ Date symptoms started: _____

Patients must have at **least one** of the following (select all that apply):

- Body Mass Index greater to or equal to 35
- Chronic Kidney Disease
- Diabetes
- Immunosuppressive Disease (i.e. CVID)
- Currently receiving immunosuppressive treatment
- ≥ 65 years of age
- ≥ 55 years of age, AND have at least one of the following: Cardiovascular disease, Hypertension, COPD or other respiratory disease

Home Infusion Orders:

- Bamlanivimab 700mg/200 ml 0.9% Sodium Chloride to be infused via gravity or infusion pump over 60 minutes x 1 dose (Must use a 0.2 or 0.22 micron filter for administration)
- 50ml 0.9% Sodium Chloride (Once infusion is complete, flush the infusion line with 50ml 0.9% Sodium Chloride to ensure delivery of required dose.)
- Anaphylaxis Kit included

4. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

Patient Signature

Date

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 Permissible

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.

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

#of Prescriptions