RIVER'S EDGE PHARMACY
PASSION FOR LIFE

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

**Covid-19 IV MAB Treatment**

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 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

RIVER'S EDGE PHARMACY

Home Infusion Orders:

- ☐ Casirivimab with Imdevimab 2,400 mg Dose for a total of 20ml given as IV into a prefilled 0.9% sodium chloride infusion bag and administer per FDA EUA protocol.
- ☐ 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 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.

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

| #of Prescriptions |
| --- |
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