Bird's Eye Medical COVID-19 Monoclonal Antibody (mAb) EUA Treatment Referral
Bebtelovimab

Patient Information

Name: _____ **Sex: M / F** **Date of birth:** _____

Weight/BMI if high risk factor: _____ **Phone:** _____ **Alt phone:** _____

Home Address: _____

NOTE: For patients with mild to moderate COVID-19 symptoms with confirmed COVID-19. This product is available for use by Emergency Use Authorization (EUA) to prevent progression of mild to moderate COVID-19 in people 12 years of age and older weighing at least 40 kg who are at high risk for progression to severe COVID-19, including hospitalization or death. This product is NOT authorized for use in patients hospitalized due to COVID-19; or who require oxygen therapy due to COVID-19; or who 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.

NOTE: Regarding COVID-19 vaccination status and mAb use. Patients receiving mAb therapy no longer need to defer vaccination per CDC.

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

Date of symptom onset: _____ Treatment should be given within **7** days of symptom onset

Date of positive COVID-19 (collection date): _____ **MUST** attach copy of positive results with referral

COVID-19 Vaccination status if known: ☐ Fully vaccinated ☐ Not vaccinated or partially vaccinated

Treatment-qualifying high-risk condition(s):

- ☐ Age
- ☐ Pregnancy
- ☐ Cardiovascular disease
- ☐ Hypertension
- ☐ Sickle cell disease
- ☐ Diabetes
- ☐ Chronic kidney disease
- ☐ Neurodevelopmental disorders
- ☐ Obesity (BMI over 25 kg/m^2) – if only risk factor is obesity, BMI should be >30 kg/m^2
- ☐ Immunosuppression disease or treatment: _____
- ☐ Having a medical-related technological dependence (i.e. tracheostomy)
- ☐ Other medical conditions or factors: _____ (see CDC website for considerations)

Monoclonal Antibody Order:

Bebtelovimab 175 mg by IV push per protocol.

Prescriber Attestation

I affirm that my patient meets above criteria for use and has been:

1. Informed that this mAb is an unapproved drug authorize for use under an **Emergency Use Authorization.**
2. Informed of alternatives to receiving this COVID-19 mAb.
3. I have discussed this treatment option with the patient and patient is agreeable to this treatment.

I am aware that:

1. Bebtelovimab will be administered as a single IV push over at least 30 seconds. Patient will be monitored in the clinic for at least 1 hour post infusion. Standard hypersensitivity reaction therapy will be provided as needed.

Signature signifies agreement of the above orders / attestation.

Provider Name (print): _____ Office Number: _____ After hours phone: _____

Provider Signature: _____ Date/Time: _____ NPI: _____

The prescribing health care provider and/or provider's designee should complete and submit a MedWatch form to FDA within 7 calendar days from the onset of a serious and unexpected adverse event that appears to be associated with the use of a monoclonal antibody.

PLEASE INCLUDE: This form plus COVID positive test results. *If possible, attach copy of problem list, allergies, last clinic or ER note, and patient medications.* Please fax to **360.878.8330.**

Bird's Eye Medical will reach out to schedule your patient asap.

For Questions call 360-688-7044 (you can ask to talk to our Provider on call, available 7 days/week)