Maryland
DEPARTMENT OF HEALTH

Maryland Referral Form
Ambulatory Monoclonal Antibody Infusion Treatment for COVID-19

Please complete the information on this form if your patient could benefit from monoclonal antibody treatment. This form should be sent to the infusion site with closest proximity to the patient (pg. 3).

Please note: CRISP eReferral is one of several referral options as noted on page 3.

**First Name: ** Last Name:

**DOB: **Age: **Sex: ☐ M ☐ F ☐ Other _____ ☐ Unknown

**Patient's Preferred Language ☐ English ☐ Spanish ☐ Other _____

**Address Line 1: Address Line 2:

City: State: County: **Zip:

County:

**Phone: ☐ cell ☐ home Secondary Phone: ☐ cell ☐ home

Allergies (medication/food/other):

Please include any additional historical patient health information. You may free text, copy/paste, or you may attach a recent clinic note or other documentation, as necessary.

Patient Eligibility:

Monoclonal antibodies directed against SARS-CoV-2 may be used in adults and children aged ≥12 years and weighing ≥40 kg who are at high risk for progressing to severe COVID-19 and/or hospitalization. Patients are considered at high risk if they meet any one of the following criteria:

- Older age (e.g., age ≥65 years of age)
- Obesity or being overweight (e.g., adults with BMI >25 kg/m2, or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts (https://www.cdc.gov/growthcharts/clinical_charts.htm)
- Pregnant
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension

The (**) indicates a required field.

- Chronic lung diseases (e.g., chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis, and pulmonary hypertension)
- Sickle cell disease
- Neurodevelopmental disorders (e.g., cerebral palsy) or other conditions that confer medical complexity (e.g. genetic or metabolic syndromes and severe congenital anomalies)
- Having a medical-related technological dependence [e.g., tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)]
- Having medical conditions and factors associated with increased risk for progression to severe COVID-19

Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19 and authorization of REGEN-COV under the EUA is not limited to the medical conditions or factors listed above. For additional information on medical conditions and factors associated with increased risk for progression to severe COVID, see the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. Healthcare providers should consider the benefit-risk for an individual patient.

Individual area health systems may have further inclusion and exclusion criteria.

Indications:

☐ Treatment of mild to moderate COVID-19 in adult and pediatric patients with positive results of direct SARS-CoV-2 viral testing in accordance with EUA criteria for dosing, administration and patient eligibility
Date of positive COVID-19 test _____ Date of symptom onset _____

☐ Post-exposure prophylaxis of COVID-19 in individuals who are at high-risk for progression to severe COVID-19 in accordance with EUA criteria for dosing, administration and patient eligibility
Date of exposure _____

I, the referring provider, am the patient's PCP or other continuity provider and have arranged for the patient to follow up with me/my designee following monoclonal antibody infusion. Or I am an ED or Urgent Care provider who will update the patient's PCP about his/her antibody infusion to arrange follow up. If the patient does not have a PCP, I will refer him/her to an appropriate provider and ensure that follow up has been arranged. [Note: Ideal timing of follow up visit is approximately 7 days post-infusion.]
☐ Indicates Provider Agreement

I, the referring provider, have advised or will advise the patient that if his/her clinical status declines by the time of the infusion appointment, the treatment may no longer be appropriate for him/her. The patient's clinical status will be re-evaluated at the infusion center at the appointment time. If the patient is deemed in need of hospital care, s/he will be referred immediately. **☐ Indicates Provider Agreement**

**** Please provide the following information:**

☐ If a patient meets the above criteria, give available EUA-approved monoclonal antibody treatment as appropriate according to the EUA dosage and administration instructions per protocol.

Provider Signature_____ Date_____

The (**) indicates a required field.

Information about both monoclonal antibody treatment can be found at FDA Emergency Use Authorization Drug and Biological Products, COVID19 Therapeutics (scroll to section on Drugs and Biologic Products).

The monoclonal infusion staff will communicate with the referring provider regarding such matters as treatment inappropriateness for patient, ultimate completion of treatment for patient, adverse events, etc

Name of Referring Site: Point of Contact:
Address:
Phone Number: Fax Number:
Email address: Preferred mode of contact: ☐ Phone ☐ Fax ☐ Email

Patient's Primary/Continuity Care Provider (if different from above)
Office Name:
Address: Phone Number:
Email address: Fax Number:

Table 1. How to Refer a Patient	
Region 1: UPMC Western Maryland	Email form to WMD-COVIDantibody@upmc.edu
Region 1: Garrett Medical Center	Fax form to 301-533-4198
Region 2: Meritus Medical Center	Fax form to 301-790-9229
Region 3: Baltimore Convention Center Field Hospital	Visit umms.org/ICReferral to submit a form via secure, HIPAA-compliant upload.
Region 3: UM Upper Chesapeake Health*	Fax referral form to 443-643-1545; or use CRISP Referral System
Region 3: Anne Arundel Medical Center	Fax form to 442-481-5744
Region 3: MedStar Harbor Infusion Center	Fax form to 443-583-0651; or visit MedStar Harbor Infusion Center Referral Form via secure link
Region 3: Hatzalah of Baltimore	Submit to Hatzalah Infusion Center Referral Form via secure link or email covidtherapy@hatzalahbaltimore.org
Region 3: Odenton Volunteer Fire Department	Call 443-459-1095
Region 3: City of Praise Family Ministries	Call 443-459-1095
Region 4: Atlantic General Hospital	Fax form to 410-641-9708
Region 4: TidalHealth	Email form to COVIDTX@Tidalhealth.org; or Fax form to 410-912-4959
Region 5: Adventist Takoma Park	Fax form to 301-891-6120
Region 5: Doctor's Community Hospital	Fax referral form to 240-542-3451
Region 5: Charles Regional Medical Center*	Fax referral form to 301-934-1798; or use CRISP Referral System
Region 5: UMMS Capital Regional Health: Laurel 3-4-5*	Call to schedule at 301-256-9234; Fax referral form to 301-256-9224; or use CRISP Referral System
Home Infusion is an available option for UMMS patient referrals on Mon-Fri 8 am – 5 pm through UM Medical Solutions. Fax: 410-636-0309	

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