

ANDREWS COUNTY HEALTH DEPARTMENT

Outpatient Monoclonal Antibody Infusion Protocol

Lincoln Center 400 NE Ave J, Andrews, TX 79714

Phone: (432) 523-2590 Fax: (432) 424-2081

Patient Name: _____

Patient DOB: _____

Patient Phone Number: _____

Patient Allergies: _____

TO ORDER: SEND THE FOLLOWING DOCUMENTATION VIA FAX: 432-524-2081

- THIS COMPLETED ORDER FORM
- POSITIVE COVID TEST DOCUMENTATION
- H&P OR DOCTORS VISIT DOCUMENT EXPLAINING HOW PATIENT MEETS CRITERIA

NOTE: Patient must **NOT** be hospitalized, require oxygen therapy **OR** require an increase in oxygen rate due to Covid-19 if using for underlying comorbidity **AND** within 10 days of symptom onset.

PATIENT INCLUSION CRITERIA- CHECK ALL THAT APPLY:

- ≥ 65 years of age
- BMI (body mass index) ≥ 25 **OR** if age 12-17 and BMI ≥ 85 th percentile for age and gender based on CDC growth charts.
- Height: _____
- Weight: _____
- Pregnancy
- Chronic Kidney Disease
- Diabetic
- Immunosuppressive Disease
- Type: _____
- Receiving Immunosuppressive Treatment
- Type: _____ > _____
- Cardiovascular disease (hypertension or congenital heart disease)
- Chronic Lung Diseases (COPD, asthma (moderate-severe), cystic fibrosis, pulmonary hypertension, or interstitial lung disease)
- Sickle Cell Disease
- Neurodevelopmental disorders (ex. cerebral palsy,) or other conditions that confer medical complexity (ex. genetic or metabolic syndromes and severe congenital anomalies).
- Having a medical related technological dependence (ex. tracheostomy gastrostomy, or positive pressure ventilation not related to COVID).

CONFIRMED COVID POSITIVE DATE: _____

TYPE OF TEST:

PCR ANTIGEN

SYMPTOM ONSET DATE: _____

Patient risk factors will be evaluated and scheduled based on available drug allocation and prescriber will be notified of outcome.

PHYSICIAN SIGNATURE: _____

DATE: _____ **TIME:** _____



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