UK HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Patient Information:
Name: ___________________________________
DOB: ___________________________________
MRN: ___________________________________

Pediatric COVID-19 Monoclonal Antibody Referral Form

This form must be completed by the referring UKHC provider and uploaded as a PDF to the patient's chart through the EPIC Media Manager function

Indication: *patient must meet both of the below criteria in addition to at least one of the listed high risk criteria*

This patient is:

☐ 12 years of age or older
☐ At least 40 kg (documented weight: ____ kg (date obtained: _________ (MM/DD/YYYY))

Select the Patient's High Risk Criteria outlined in the EUA include the following: *select all that apply*

☐ Obesity or being overweight (BMI ≥ 85% for their age and gender on CDC growth charts)
☐ Chronic kidney disease
☐ Diabetes
☐ Immunosuppressive disease or immunosuppressive treatment
☐ Cardiovascular disease (including congenital heart disease)
☐ Sickle cell disease
☐ Pregnant
☐ Chronic lung disease (moderate to severe asthma, interstitial lung disease, cystic fibrosis and pulmonary hypertension)
☐ Neurodevelopmental disorders or other conditions that confer medical complexity (i.e., cerebral palsy, genetic/metabolic syndromes, severe congenital anomalies)
☐ Medical-related technological dependent (i.e., tracheostomy, gastrostomy, positive pressure ventilation not related to COVID-19)
☐ Other medical conditions/factors associated with increased risk for progression to severe COVID, per CDC website
If other, please specify: ____

☐ **Treatment**

1. ☐ Mild to moderate COVID-19 infection with **positive** results of direct SARS-CoV-2 viral testing (PCR or antigen):
   - Date of SARS-CoV-2 Test: _________ (MM/DD/YYYY)
   - Date of Symptom Onset:_________ (MM/DD/YYYY) [patient must be within **7 days** of symptom onset]

AND

2. ☐ At least **two** of the following symptoms: *select all that apply*

   ☐ Fever ☐ Cough ☐ Sore Throat ☐ Shortness of Breath
   ☐ Malaise ☐ Headache ☐ Myalgias ☐ Gastrointestinal Symptoms
   ☐ Other: ________________________

☐ **I have provided the patient's legal guardian with a copy of the Fact Sheet for Parents and Caregivers** (English; Spanish)

Legal Attestation:

________________________(First Name, Last Name) is a _______________ (age) year old ____________ (gender) under my care for COVID-19. I have assessed my patient as eligible to receive bebtelovimab under the FDA Emergency Use Authorization (EUA). I have reviewed the mandatory requirements for drug use within the Fact Sheet for Health Care Providers and obtained approval for use according to institutional policy. I have provided information consistent with the Fact Sheet for Patients and Parents/Caregivers EUA of bebtelovimab and given the patient/legal representative a copy. The patient/legal representative was informed of the potential risks and benefits of bebtelovimab, alternatives to bebtelovimab, and that bebtelovimab is an unapproved drug that is authorized for use under EUA. The patient or patient's legal representative has expressly agreed to this treatment.

______________________________	______________	______________
Signature, Referring Provider	Date (MM/DD/YYYY)	Contact Information