## COVID-19 Monoclonal Antibody (mAb) EUA Treatment Referral

**Patient Information**

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

**Allergies: _____**

**Address: _____ City/Prov: _____/_____**

**Postal: _____ Phone: _____ HCN: _____**

**NOTE: For patients with mild COVID-19 with confirmed COVID-19.** These products are available for use under an interim authorization (Interim Order) by Health Canada to prevent progression of mild to moderate COVID-19 in adults and pediatric patients (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.

In order to qualify for therapy, patients need to be a) within 7 days of symptom onset and b) Meet 1 criteria under vaccinated or unvaccinated

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

- ❑ **Date of symptom onset:** _____ Treatment must be given within 7 days of symptom onset.
- ❑ **Symptoms: _____**
- ❑ **Date of positive COVID-19 test:** _____
- ❑ **Does this person have a history of prior COVID-19 within the past 90 days?**
- ❑ **Has this person received at least one dose of vaccine ?**
  - ☐ Yes – do they have any of the following criteria
    - ☐ Cancer on active treatment (e.g., chemotherapy) (Please specify: _____)
    - ☐ Hematologic malignancy or Bone Marrow Transplant (Please specify: _____)
    - ☐ Solid Organ Transplant (Please specify: _____)
    - ☐ Anti-CD20 agent (Please specify drug: _____)
  - ☐ No – do they have any of the following criteria?
    - ☐ Age >= 50
    - ☐ Obesity
    - ☐ Cardiovascular disease or Hypertension (Please Specify: _____)
    - ☐ Chronic lung disease (Please specify: _____)
    - ☐ Chronic metabolic disease including diabetes (Please specify: _____)
    - ☐ Chronic Kidney Disease
    - ☐ Chronic Liver Disease
    - ☐ Immunosuppressed or on immunosuppressants (Please Specify: _____)

.

**Prescriber Attestation** (Must be checked to be eligible for treatment)

❑ I affirm that my patient meets above criteria for use;

Physician Name (print): _____ Direct Contact Number (not office line): _____

Physician Signature: _____ Date/Time: _____/_____ CPSO: _____

**Fax to: 905-522-4469**