



Mobile Integrated Healthcare
 Covid Response Team

ALERT AMBULANCE SERVICE, INC.
 MONOCLONAL ANTIBODY TREATMENT FOR SARS-COV-2
 MEDICATION ORDER FORM
 Version 3.29.22

ONCE COMPLETED AND SIGNED BY PROVIDER PLEASE FAX THIS FORM TO 1-401-574-2045 OR VIA SECURE E-MAIL TO AlertMIHC@AlertEMS.com

Dear Provider: Thank you for considering your patient for a monoclonal antibody treatment against SARS-CoV-2 as an outpatient treatment that may decrease chance of hospitalization for COVID-19. Monoclonal antibody infusions are authorized under an FDA Emergency Use Authorization (EUA) are **not indicated in patients requiring supplemental oxygen above their baseline (if on baseline 02, no increase in liters) or in those meeting criteria for hospitalization.** Due to limited supply, **patients most likely to benefit will be prioritized.**

PATIENT DEMOGRAPHIC INFORMATION		
Name:	DOB:	Age:
Gender:	Race:	Phone:
Address/City/Zip:		
Insurance 1:	Policy#:	Group#:
Insurance 2:	Policy#:	Group#:
If patient over 65 & has Blue Chip, UHC, Tufts - SSN# or Medicare #:		
If Policy holders Name is Different:	Name:	DOB:
Patient Scheduling Contact Info:	Name:	Phone:
Patient surrogate decision-maker:	Name:	Phone:
ADDITIONAL PATIENT INFORMATION		
If patient is NON-Ambulatory, explain:		
Date of Symptom Onset (must be within 7 days of onset to qualify):		
Date of first positive test for SARS-CoV-2 or Date of Exposure:		
If patient is on home oxygen, what is their baseline requirement? (lpm)		
PATIENTS RELEVANT MEDICAL HISTORY		
Weight (kg):	Height (in):	BMI:
Current Medications:		
Past Medical History:		
Allergies:		
Is the patient pregnant?		



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PROVIDER INFORMATION		
Full Name:	NPI#:	Phone:
Address:		Fax:
PROVIDER MEDICATION ORDER		
<p>As the ordering provider, I attest that the above patient information is correct as of the date/time below. As the ordering provider I understand that the patient may receive any one of the three monoclonal antibody treatments listed below based on current supply:</p> <p><input type="checkbox"/> Order SARS-CoV-2 monoclonal antibody once per protocol.</p> <ul style="list-style-type: none"> • Medication brand/manufacturer/type will be based on current CDC variant data, CDC guidelines and recommendations, and medication availability. 		
Ordering Providers Signature:		
	Date:	Time:
PROVIDER DECLARATION		
<p>Whether provided in person or virtually, I confirm that this patient or legal representative has received a full explanation about the nature and purpose of monoclonal antibody treatment, the risks involved in receiving medications used for monoclonal antibody treatment, and treatment alternatives. The patient confirms that he/she has received answers to all his/her questions, and to the best of my knowledge, I believe the patient has been adequately informed and has consented.</p> <p>Ordering Provider has reviewed FDA EUA with patient/caregiver and has (must select all below for eligibility):</p> <p><input type="checkbox"/> Given the “Fact Sheet for Patients, Parents and Caregivers”</p> <p><input type="checkbox"/> Informed of alternatives to receiving the COVID-19 antibody treatment</p> <p><input type="checkbox"/> Informed that the COVID-19 monoclonal antibody is an unapproved drug that is authorized for use under this EUA</p>		
Providers Declaration Signature:		
	Date:	Time: