

COVID-19 Monoclonal Antibody (mAB) EUA Treatment Referral

Fax Received
Date/Time

Regional Sites (Please select one and fax to listed number)

- | | | |
|--|---|---|
| <input type="checkbox"/> AGH 807-597-1210 | <input type="checkbox"/> DRHC 807-223-8843 | <input type="checkbox"/> SLMHC 807-737-5271 |
| <input type="checkbox"/> RHCf 807-274-4839 | <input type="checkbox"/> NOSH-Wilson 807-229-0847 | <input type="checkbox"/> SJCG Homes 807-345-0230 |
| <input type="checkbox"/> LWDC 807-468-3351 | <input type="checkbox"/> GDH 807-854-4202 | <input type="checkbox"/> TBRHSC Assessment Centre Fax: 807-623-6631
Tele: 807-935-8101 |
| <input type="checkbox"/> RLMCMH 807-727-2217 | <input type="checkbox"/> NDHC 807-887-3393 | <input type="checkbox"/> Other Facility _____ |

Patient Information

Name: _____ Date of Birth: _____
Allergies: _____
Address: _____ City/Prov: _____
Postal: _____ Phone: _____ HCN: _____

Note: For patients with confirmed COVID-19, with MILD symptoms. 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 a) Be symptomatic; b) Be within 7 days of symptom onset; c) Meet 1 criteria listed below under vaccinated or unvaccinated; d) Be willing to travel to the specified site to receive therapy; e) Expected survival greater than 1 year from all causes.

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 last 90 days? (circle one) YES NO
- Has this person received at least two (2) doses of vaccine?
 - YES** – do they meet any of the following criteria?
 - Hematologic Malignancy or Bone Marrow Transplant (Please specify: _____)
 - Solid Organ Transplant (Please specify: _____)
 - Significant immunosuppression (Please indicate type: high-dose corticosteroids >2 weeks, alkylating agents, antimetabolites, cancer chemotherapy, TNF inhibitors, anti-CD20 agents and other immunosuppressive biological agents)
 - Primary Immunodeficiency (Please specify: _____)
 - Advanced or untreated HIV
 - NO** – do they meet any of the following criteria?
 - Age >= 60
 - Age >= 50 AND at least one of the following
 - Indigenous (First Nations, Inuit, or Metis)
 - Obesity (BMI >= 30)
 - Diabetes Mellitus
 - Chronic Kidney Disease (GFR < 15, or dialysis)
 - Immunosuppressed or on immunosuppressants as above (Please specify: _____)
 - Sickle Cell Disease
 - Intellectual Disability
 - Cerebral Palsy
 - Other severe risk factor (Please specify: _____)

Referral Attestation (Must be checked to be eligible for treatment)

- I affirm that my patient meets above criteria for use

Dosing Information:

Sotrovimab 500 mg IV x 1 dose

Clinician Name (Print): _____ Direct Contact Number (not office line): _____
Clinician Signature: _____ Date/Time: _____ CPSO#: _____

