Coram®
CVS specialty® infusion services

Bamlanivimab for COVID-19 Fax Cover Sheet

Fax to 866-843-3221 Intake Phone Number 866-316-0264

☐Prescriber ☐Patient ☐ Other_____ Agrees to the following:

☐ I understand this drug is not authorized for use in hospitalized coronavirus disease 2019 (COVID-19) patients, patients requiring oxygen therapy due to COVID-19, or in those patients on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity who require an increase in baseline oxygen flow rate due to COVID-19. The patient or his/her guardian have provided their informed consent for the administration of Bamlanivimab.

☐ I understand Bamlanivimab should only be used for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older weighing at least 40 kg, and who are at high risk for progressing to severe COVID-19 and/or hospitalization, and when the known and potential benefits to patients outweigh the known and potential risks of such product.

Patient Information (complete or include demographic sheet)

Is this patient in a facility? ☐ Y or ☐ N If yes, Name of the Facility: _____

If yes, who is the primary point of contact at facility? Name, title_____ Phone _____

Patient Power of Attorney (If applicable) Name_____ Phone_____

Patient Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Patient Primary Phone: _____ Patient Alternate Phone: _____

Patient Address: _____ City: _____ State: ___ ZIP Code: _____

Height: ____ in/cm Weight: ____ lb/kg Allergies (include reaction): _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Provide a copy of the patient insurance card(s) Medicare/Medicaid ID Number_____

Prescriber Information (complete or include demographic sheet)

Affiliated Hospital or Group:_____

Office Contact: _____ Contact Phone Number: _____

Prescriber Name: _____ Prescriber Phone: _____

Prescriber Address: _____ City: _____ State: ___ ZIP Code: _____

State License #: _____ NPI#: _____ DEA#: _____

Physician Email Address: _____

Clinical Information

Date of positive COVID-19 test result: _____ Date of symptom onset and disease manifestation: _____

Adult Patient meets at least one of the following criteria: (check all that apply)

☐ Has a body mass index (BMI) ≥35 ☐ Has chronic kidney disease ☐ Has diabetes ☐ Has immunosuppressive disease
☐ Is currently receiving immunosuppressive treatment ☐ Is ≥65 years of age

OR

☐ Patient is ≥55 years of age **AND has** ☐ Cardiovascular disease **OR** ☐ Hypertension OR ☐ Chronic obstructive pulmonary disease/other chronic respiratory disease

OR

Pediatric Patient must meet the following: (check all that apply)

☐ Patient is 12-17 years of age **AND has** ☐ BMI >85th percentile for their age and gender based on the CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm **OR** ☐ Sickle cell disease **OR** ☐ Congenital or acquired heart disease **OR** ☐ Neurodevelopmental disorders, for example, cerebral palsy **OR** A medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19) **OR** ☐ Asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

Please fax the following documents to complete this referral:

☐ Bamlanivimab Orders and Acute Infusion Reaction Prescription and Treatment Guidelines (required for all patients)
☐ History & Physical ☐ Recent clinical notes (reason for therapy) ☐ List of current medications ☐ Anaphylactic Kit (**all patients**)

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates. 75-53375A 020221