St. Lawrence Health Bebtelovimab order form

Patient name: ____

DOB: ____/_____/________ **Age:** _____ **Weight**: ______kg

Phone #: ____________________

Allergies: ____

First COVID+ date ____/_____/________
eligible if first positive test is within **7 days**

Vaccination status

- ☐ Fully Vaccinated with booster
- ☐ Fully vaccinated
- ☐ Partially/Unvaccinated

High risk criteria mark ALL that apply

- ☐ BMI 25+
- ☐ Diabetes mellitus
- ☐ Chronic kidney disease
- ☐ Immunosuppressive disease/treatment
- ☐ Cardiovascular disease
- ☐ Hypertension
- ☐ Chronic lung disease
- ☐ Medical related technological dependence (ie tracheostomy, gastrostomy etc.)
- ☐ Neurodevelopmental disorders
- ☐ Non-white race
- ☐ Sickle Cell disease
- ☐ Pregnancy

- ☐ **Bebtelovimab 175 mg IV push over ≥30 seconds**
  - ☐ **ED immediate use**
  - ☐ **Scheduled out-patient use**

Provider (print)______________________________ **Signature** _______________________

Date: ____/_____/________

Initial below:

______EUA consent performed

______Attestation- patient does not require supplemental oxygen beyond baseline

CPH pharmacy fax: 315-261-5513 **MH pharmacy fax:** 315-769-4630 **GH ED fax:** 315-261-5738

Last update 1/13/2022