COVID-19 Monoclonal Antibody (mAb) EUA Treatment Referral

Regional Sites (Please select one, walk-in not accepted):

- ☐ Health Sciences North – COVID Assessment Centre, 2050 Regent St, Sudbury, **Fax: 705-523-4464**
- ☐ Humber River Hospital – Finch RCC, COVID Assessment Centre, 2111 Finch Ave W, North York, **Email:** CACfinch@hrh.ca
- ☐ The Ottawa Hospital – Civic Campus, 1052 Carling Ave, Ottawa, **Fax: 613-739-6751**
- ☐ Scarborough Health Network – Centenary Hospital, 2867 Ellesmere Rd, Scarborough, **Fax: 416-281-7384**
- ☐ St. Joseph's Healthcare Hamilton – ED Entrance, 50 Charlton Ave East, Hamilton, **Fax: 905-522-4469**
- ☐ Thunder Bay Regional Health Sciences Centre – 984 Oliver Rd, Suite 101, Thunder Bay, **Fax: 807-623-6631,** Tele: 807-935-8101
- ☐ Windsor Regional Hospital – 1030 Ouellette Ave, Windsor, **Email:** WRHmAbclinic@wrh.on.ca

Patient Information

Name:_____ **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 a) Be symptomatic b) Be within 7 days of symptom onset c) Meet 1 criteria under vaccinated or unvaccinated d) Be willing to travel to the clinic to receive therapy e) Expected survival > 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 past 90 days?**
- ☐ **Has this person received at least two doses of vaccine?**
  - ☐ Yes (2 or more doses) – 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 biologic agents)
    - ☐ Primary immunodeficiency (Please specify:_____)
    - ☐ Advanced or untreated HIV
  - ☐ No (0 or 1 doses) – do they meet any of the following criteria?
    - ☐ Age >= 60
    - ☐ Age >= 50 AND at least one of the following:
      - ☐ Indigenous (First Nations, Inuit, or Métis)
      - ☐ Obesity (BMI >= 30)
      - ☐ Diabetes Mellitus
      - ☐ Chronic Kidney Disease (GFR < 15 or dialysis)
      - ☐ Immunosuppressed 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

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

Clinician Signature:_____ Date/Time:_____/_____ College #: _____