Fax this form to 833-371-2084 or email to Care@rangeuc.com
Please Note: A copy of the positive COVID-19 test result MUST be sent with this page

PROVIDER REFERRAL FOR REGEN-COV (CASIRIVIMAB AND IMDEVIMAB) INFUSION TREATMENT

Referring Provider Name:_____

Referring Facility Name:_____

Referring Provider Phone:_____ Fax:_____

Patient Information

Patient Name:_____

Patient Address:_____

Patient Phone Number:_____Age:____ Date of Birth:_____

Does the patient have insurance coverage? ☐ Yes ☐ No

If yes, provide the insurance information. If no, please provide patient SSN:_____

Carrier:_____

Subscriber ID:_____Group:_____

Health Information

Age:_____
Weight:_____
Spo2:_____
Symptom onset date:_____
Date of positive test:_____

At least 12 years of age: □ Yes □ No
Weighs at least 40 kg: □ Yes □ No
Is not hospitalized: □ Yes □ No
Does the patient require oxygen? □ Yes □ No

Please check any of the following medical conditions or other factors that may place the patient at higher risk progression to severe COVID-19:

☐ 65 years of age or older

☐ Chronic lung disease

☐ Smoker

☐ Sickle cell disease

☐ Has a medical-related technological dependence

☐ Adult with BMI > 25 OR child age 12-17 with a BMI ≥85th percentile for their age and gender based on CDC growth charts

☐ Other:_____

☐ Pregnancy

☐ Chronic kidney disease

☐ Diabetes

☐ Cardiovascular disease

☐ Immunosuppressive disease or immunosuppressive treatment

☐ Substance use disorder

☐ Neurodevelopmental disorder (i.e., cerebral palsy) or conditions that confer medical complexity (i.e., genetic syndrome)

Is the patient vaccinated for COVID-19? ☐ Yes ☐ No

Provider Signature:_____

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