GUAM REGIONAL MEDICAL CITY
Where Patients are Partners

BAMLANIVIMAB REFERRAL FORM

Patient Name: _____ **Date of Birth:**_____

Mobile Phone: _____ **Other Phone (Type):** _____

Insurance Provider: _____
Note that the medication is being provided by the federal government without cost. The expenses associated with the infusion will be billed to the appropriate insurance provider. Special assistance/arrangements will be made for those uninsured or underinsured.

IF YOUR PATIENT REQUIRES OXYGEN THERAPY BECAUSE OF COVID-19, THEY ARE NOT A CANDIDATE FOR BAMLANIVIMAB. PLEASE CONSIDER REFERRING THEM TO THE EMERGENCY DEPARTMENT FOR FURTHER EVALUATION AND POSSIBLE HOSPITAL ADMISSION.

Which of the following inclusion criteria(s) does your COVID-19 patient meet for the infusion of bamlanivimab? ***(check all that apply)***

- ❑ Has a body mass index (BMI) ≥35 (specify): _____
- ❑ Has chronic kidney disease
- ❑ Has diabetes
- ❑ Has immunosuppressive disease (specify): _____
- ❑ Is currently receiving immunosuppressive treatment
- ❑ Is ≥65 years of age
- ❑ Is ≥55 years of age AND has
  - ❑ cardiovascular disease, OR
  - ❑ hypertension, OR
  - ❑ chronic obstructive pulmonary disease/other chronic respiratory disease.
- ❑ Is 12 – 17 years of age AND have
  - ❑ BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm, OR
  - ❑ sickle cell disease, OR
  - ❑ congenital or acquired heart disease, OR
  - ❑ neuro developmental 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.

Notes/Comments:

_____

_____

Referring Provider: _____ **Date:** _____

Referring Clinic/Facility and Phone: _____

This referral is limited to the infusion of bamlanivimab and immediate post-infusion monitoring. Patient will be instructed to isolate, and follow-up as directed with referring provider.

PLEASE SEND REFERRAL VIA:
Fax: 671-969-4929
and/or
Email: COVID.outpatient@GRMC.gu

To speak directly with an infusion provider, please contact:
Felix Cabrera, MD or Greg Woodard, NP via
GRMC Main Line: 671-645-5500

N.01G5