



Monoclonal Antibody for the Treatment of COVID-19

Bebtelovimab

Inclusion/Exclusion Criteria Checklist

(Fax to Pharmacy: CMMC: 795-5675)

Apply Patient Sticker
Here

Date:	Prescribing Provider:
Patient Name/FIN (if no sticker):	Site of Administration: CMMC RH BH mAb Clinic

Inclusion criteria (Check all that Apply) Must meet all Criteria:

<input type="checkbox"/>	Confirmed positive results of direct SARS-CoV-2 viral testing In previous 7 days (should be given as soon as possible after a positive viral test for SARS-CoV-2)	<input type="checkbox"/>	Mild to moderate symptoms not requiring supplemental oxygen (or not greater than baseline, if on baseline oxygen) due to COVID-19
<input type="checkbox"/>	Not hospitalized due to COVID-19 (Use may be considered in patients hospitalized for reasons other than COVID-19, so long as the terms and conditions of the EUA are met)	<input type="checkbox"/>	Presents within 7 days of symptom onset
<input type="checkbox"/>		<input type="checkbox"/>	Age greater than or equal to 12
<input type="checkbox"/>		<input type="checkbox"/>	Adults can be treated regardless of their weight; pediatric patients (12 to 17 years old) must weigh at least 40 kg

If all the above Inclusion Criteria are met, patients must have at least one high risk factor for progressing to severe COVID-19

(Check all that apply).

<input type="checkbox"/>	Older age (for example age ≥65 years of age)	<input type="checkbox"/>	Chronic lung diseases (chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
<input type="checkbox"/>	Having a medical-related technological dependence (tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))	<input type="checkbox"/>	Obesity or being overweight (adults with BMI >25 kg/m ² , or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)
<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Other Risk Factor: _____ Other medical conditions or factors (race or ethnicity) may also place individual patients at high risk and use is not limited to those listed. For additional information on medical conditions and factors associated with increased risk for progression to severe COVID-19, see the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (Google search CDC People with Certain Medical Conditions)
<input type="checkbox"/>	Sickle cell disease		
<input type="checkbox"/>	Chronic kidney disease		
<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	Immunosuppressive disease or treatment		
<input type="checkbox"/>	Cardiovascular disease (including congenital heart disease) or hypertension		
<input type="checkbox"/>	Neurodevelopmental disorders (cerebral palsy) or other conditions that confer medical complexity (genetic or metabolic syndromes and severe congenital abnormalities)		

I attest to the following:

- I have provided and reviewed the information consistent with the FDA "Fact Sheet for Patients, Parents and Caregivers" with the patient/caregiver
- Obtained drug specific written consent and faxed to pharmacy
- Informed the patient/caregiver of alternatives to receiving a monoclonal antibody for the treatment of COVID-19
- Informed the patient/caregiver that this monoclonal antibody is an unapproved drug that is authorized for use under this EUA
- I am responsible for reporting of all serious adverse events and medication errors to the FDA within 7days
- Patient will be Clinically monitored during infusion and **observed for at least 1 hour after infusion is complete**

Provider Name: _____ Provider Signature: _____ Date: _____