Sotrovimab Infusion

Order Form for COVID-19 Monoclonal Antibody (MAB) Therapy

Step 1: Complete form and fax to: 888-972-4110 along with a copy of positive COVID-10 result and a copy of insurance card if available
Step 2: Once the paperwork has been received, a pharmacy representative will contact the patient to coordinate services as soon as possible

Indication: Emergency Use Authorization (non-FDA approved) for treatment of mild-to-moderate coronavirus disease (COVID-19) in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death

The patient must meet one of more of the criteria below to be considered high-risk. Please circle the applicable criteria this patient meets:	Sotrovimab is not authorized for use in patients:
● ≥65 years of age ● BMI >25 kg/m2 , or if 12 to 17 years of age, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm ● Pregnancy ● Chronic kidney disease ● Diabetes ● Immunosuppressive disease ● Cardiovascular disease (including congenital heart disease) or hypertension ● Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension) ● Sickle cell disease ● Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies) ● Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation [not related to COVID 19]) ● Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19	● < 12 years of age ● < 40 kg ● Who are hospitalized due to COVID-19, OR ● Who require oxygen therapy due to COVID-19, OR ● Who require an increase in baseline oxygen flow rate due to COVID-19 (in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity).

Medication ordered: Sotovimab
Dose ordered (Indication specific): 500mg IV once

Patient Name (Last, First, MI): ____________________ Date of Birth: ________ Sex: ____ Weight: ____ Height: ___ in.
Phone number: __________ Address: ____________________________________ SSN: ____________

DIAGNOSIS:

A. Mild to moderate COVID-19 Date of Symptom Onset: _______*

*Symptom onset must be within 7 days of infusion

I acknowledge that administering and monitoring of the treatment will be billed to the patient's insurance and they may incur a charge: ___yes

I attest that the patient meets the above criteria and have provided the patient/caregiver with the "Fact Sheet for Patients, Parents, and Caregivers" for Sotovimab, informed of alternatives to receiving sotrovimab informed that this medication is an unapproved drug that is authorized for use under the Emergency Use Authorization, and documented all of this in the patient's medical record.

Provider Full Name: ____
NPI: ____
Address: ____
Office Contact: ________________________ Fax: ________________________
Signature/Date/Time:____

Disclaimer: If you have received this information in error or if you are requesting that transmissions cease in the future, please notify the sender to be removed as the recipient of future transmissions. Notify the sender by fax: 402-895-7655, call 402-973-1919 or email dkohll@kohlls.com