San Joaquin General Hospital
And
San Joaquin County Clinics

SOTROVIMAB Referral Form

Dear Provider,

Thank you for referring your patient for SOTROVIMAB infusion as an outpatient treatment for Covid 19.

Based on the Emergency Use Authorization of SOTROVIMAB:

1. Inclusion Criteria for patients who have laboratory confirmed SARS-CoV-2 infection either by antigen or molecular PCR Test at higher risk for progressing to severe Covid-19 includes but is not limited to the following conditions:
    - Adult or Pediatric Patient (12 years of age and older weighing at least 40 kg).
    - Have at least one symptom of mild or moderate Covid-19
    - Onset of symptoms ≤ 10 days
    - Age ≥ 65 years
    - BMI ≥ 25 kg/m2
    - Pregnancy
    - Chronic kidney disease
    - Diabetes
    - Immunosuppressive disease or treatment
    - Cardiovascular disease including hypertension
    - Chronic lung disease
    - Sickle cell disease
    - Neurodevelopmental disorders
    - Having a medical-related technological dependence
    - Other medical conditions or factors such as race or ethnicity that may place the individual patient at high risk for progressing to severe Covid-19

2. Patients with any of the following exclusion criteria **will not** be eligible for treatment:

    - Onset of symptoms > 10 days prior to start of treatment
    - Need for hospital admission
    - Requiring supplemental oxygen OR requiring increase in baseline oxygen flow rate if on chronic oxygen supplementation
    - Presence of any condition likely to predict poor clinical outcome with SARs-Covid-19

San Joaquin General Hospital
And
San Joaquin County Clinics

SOTROVIMAB Referral Form

Basic demographic information

Patient Name: _____

Date of Birth: _____ Age: _____ Telephone: _____

Preferred Language: _____

Referring Provider's name: _____

Referring Provider's phone number: _____

Referring Provider's address: _____

Provider has reviewed FDA EUA with patient for SOTROVIMAB and patient consents to proceed.

☐ Yes

COVID19 related information

Date of symptom onset: _____

Date of positive test for SARS-CoV-2 (COVID-19): _____

Is the patient on home oxygen at baseline? ☐ Yes ☐ No

If yes, what is the patient's baseline oxygen requirement? _____ L/min

What is the patient's current oxygen requirement? ☐ None (room air) ☐ _____ L/min

Relevant Medical History

Patient's weight (kg): _____ Patient's height (inches): _____ BMI: _____

Current medications: _____

Allergies _____

Is the patient pregnant? ☐ Yes ☐ No

San Joaquin General Hospital
And
San Joaquin County Clinics

SOTROVIMAB Referral Form

Please check if patient has history of any of the following

- ☐ Age ≥ 65
- ☐ Body Mass Index (BMI) ≥ 25
- ☐ Cardiovascular disease
- ☐ Hypertension
- ☐ Chronic lung or pulmonary disease
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease (not including diabetes)
- ☐ Use of immunosuppressive agents

Referring Provider will obtain patient consent for treatment:

- Provide patient with fact sheet for SOTROVIMAB
- Inform of alternatives to SOTROVIMAB
- Must inform patient that SOTROVIMAB is authorized for Emergency Use only and is not approved by FDA to treat Covid 19.

If patient meets inclusion criteria and consents to treatment Provider or representative will call:
(209) 468- 6820 to schedule next available appointment.

Patient is to bring a copy of signed consent and referral documents to infusion appointment.