Request to Access Sotrovimab: Adults

Please email completed forms to CTWG@health.qld.gov.au and nominated pharmacy delegate at your hospital

Please note: this medication is regulated by the National Medical Stockpile. Access to stock requires completion of this form and confirmation by the prescriber that the patient fulfils required criteria.

Supply of COVID-19 therapeutics is currently through the National Medical Stockpile (NMS) and availability may fluctuate with demand and constraints in the supply chain.

Please check your patient meets eligibility for these medicines prior to completing the form(s).

PATIENT DETAILS

Patient initials:

URN:

Patient DOB:

Gender: -- Select one --

Patient weight:

HHS: -- Select one --

Hospital/Facility:

Is the patient pregnant? -- Select one --

Is the patient breastfeeding? -- Select one --

ACCESS CRITERIA

The patient must meet ALL access criteria:

- ☐ Confirmed SARS-CoV-2 positive
- ☐ Age ≥ 18 years
- ☐ No oxygen requirement (unless chronic lung disease on home oxygen)
- ☐ Symptomatic disease within 5 days of symptom onset

ADMINISTRATION

Infusion date:

Location of infusion: -- Select one --

COVID TEST

Date of positive test

Test type -- Select one --

Pathology provider -- Select one --

Date of symptom onset

VACCINATION

Vaccination status -- Select one --

ELIGIBILITY

Is the patient eligible for treatment according to criteria?

-- Select one --

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IMMUNOSUPPRESSION

Please select the patient's immunosuppression status (if applicable)

- ☐ Solid organ transplant on immunosuppressive therapy
  - Specify organ:
- ☐ Haematopoietic stem cell transplant
  - Please select: -- Select one --
- ☐ Active haematological malignancy
- ☐ Non haematological malignancy on current active treatment
- ☐ HIV with CD4 count < 250 cells/microlitre or unable to be established on effective treatment
- ☐ Primary immunodeficiency
  - Please specify immunodeficiency:
- ☐ On immunosuppressive therapy
  - Please specify immunosuppressant(s):

RISK FACTORS

Select applicable risk factors

- ☐ Age ≥ 50 years
- ☐ Aboriginal or Torres Strait Islander ≥ 30 years
- ☐ Obesity (BMI ≥ 30 kg/m^2)
- ☐ Renal impairment (eGFR < 60 mL/min)
- ☐ Serious cardiac conditions (heart failure, CAD, cardiomyopathies, hypertension)
- ☐ Respiratory compromise (e.g. COPD, mod-severe asthma, bronchiectasis)
- ☐ Diabetes (Type I or II requiring medication)
- ☐ Medical related technologic dependence (BiPAP, other ventilation not related to COVID-19)
- ☐ Neurodevelopment disorders (including Cerebral Palsy, Down's Syndrome etc)
- ☐ Sickle Cell Disease
- ☐ Patients with neuromuscular disease with respiratory muscle involvement
- ☐ Disability with multiple comorbidities or frailty
- ☐ Neurological conditions (e.g. stroke, dementia, demyelinating condition)
- ☐ Cirrhosis
- ☐ Patient in RACF
- ☐ Lack of access to higher level healthcare or remote (MMM Cat 5 or above)

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PRESCRIBER DETAILS

Prescriber full name:

Email:

Position: Phone:

APPROVER DETAILS (if required at your site)

Name of approving Infectious Diseases Physician/COVID delegate:

Email:

Position: Phone:

Date of approval:

Name of pharmacist consulted:

Acknowledgement

- ☐ I declare that the information provided is accurate at the time of completion
- ☐ I declare that I have discussed the risks and benefits of treatment with the patient and/or their carer and provided a Patient Information Leaflet
- ☐ I agree to report any adverse reactions via the local reporting process
- ☐ I agree to provide outcome information when requested