Request to Access Sotrovimab: Children's Health

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.

Fulfilling eligibility criteria does not automatically result in prescription of sotrovimab in children and it is currently reserved for those at the very highest risk of disease progression.

The use of sotrovimab in children and adolescents requires the approval of a specialist Paediatric Infectious Diseases Physician.

For guidance, detailed definitions and risk stratification, refer to the Paedaitric Guideline CHQ-GDL-63327

PATIENT DETAILS

Patient initials:

URN:

Patient DOB:

Gender: -- Select one --

Patient weight:

HHS: -- Select one --

Patient age:

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
- ☐ No oxygen requirement (unless chronic lung disease on home oxygen)
- ☐ Less than 5 days from symptom onset

ADMINISTRATION

Infusion date:

COVID TEST

Date of positive test:

Test type: -- Select one --

Pathology provider: -- Select one --

Date of symptom onset:

VACCINATION

Vaccination status: -- Select one --

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IMMUNOSUPPRESSION

☐ Patient is immunosuppressed

Please provide details of immunosuppression:

RISK FACTORS

Select applicable risk factors. Mandatory if patient not immunosuppressed.

Any ONE of:

- ☐ Complex life limiting neurodisability with respiratory involvement
- ☐ Obesity (BMI ≥ 95th [CDC] / ≥ 97th [WHO] centile for age)
- ☐ Chronic lung disease, severe
- ☐ Heart failure
- ☐ Severe asthma

OR any TWO of:

- ☐ Diabetes (insulin dependent)
- ☐ Moderate-severe asthma not fulfilling severe criteria
- ☐ Chronic kidney disease (GFR < 15 mL/min/1.73m^2)
- ☐ Sickle cell disease
- ☐ Complex genetic disease
- ☐ Complex metabolic disease
- ☐ Complex chronic gastrointestinal disease
- ☐ Multiple congenital anomalies
- ☐ Trisomy 21

If the patient does not meet the above eligibility requirements, please justify rationale for use:

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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 ADR portal
- ☐ I agree to provide outcome information when requested
- ☐ For off label/ off license use, I have requested and received approval from the local hospital/ health service Medication Advisory Committee/ Executive Director for Medical Services