Fax a copy of this completed form and a copy of the positive COVID test to 915- 577- 6192

Casirivimab/Imdevimab Infusion Patient Screening Form

Patient Name: _____ **Todays Date:** _____/_____/_____

D.O.B.: _____/_____/_____ **Cell Phone:** _____

Onset of mild to moderate COVID-19 symptoms: _____/_____/_____

Symptoms less than 10 days? ☐ yes ☐ **no** STOP **NOT ELIGIBLE**

SpO2_____% > 90% ☐ *yes* ☐ ***no*** STOP ***NOT ELIGIBLE***
With no new or increase O^2

Stable for discharge home: ☐ *yes* ☐ ***no*** STOP ***NOT ELIGIBLE***

Weight: _____

Height: _____

Allergies:
_____
_____
_____

REGEN-COV treatment should be considered for high-risk individuals ages 12 and up and weighing at least 40 kg

Other medical conditions or factors (for example, race or ethnicity) may also place individual patients at high risk for progression to severe COVID-19 and authorization of REGEN-COV. **Healthcare providers should consider the benefit-risk for an individual patient.**

Post-Exposure Prophylaxis exposure date _____ ☐ yes ☐ no

Date of COVID test: _____/_____/_____ COVID test result positive ☐ yes ☐ **no**

Positive Test Type: ☐ PCR ☐ Antigen

Infusion Appointment: _____/_____/_____ at _____:_____ (**must be within 10 days of symptoms onset**)

☐ **Casirivimab 600 + Imdevimab 600 mg intravenous (IV) infusion**

Physician/APP: _____ _____

Print name Signature

Provider Phone: _____

Provide patient with instructions, and copy of screening form and Map with directions to infusion center.

Fax a copy of this completed form and a copy of the positive COVID test to 915- 577- 6192