# Bebtelovimab Patient Screening Form

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

**D.O.B.:** ______/_______/__________ **Screening Location:** ________________________________

**Cell Phone:** ___________________________ **Email address**: ____________________________________

Onset of mild to moderate COVID-19 symptoms: __________/________/_______

**Wt.** __________

**Ht.** ___________

**Allergies:**

______________

______________

**Symptoms less than 7 days?** ☐ *yes* ☐ **no**

**NOT ELIGIBLE**

**SpO2________% > 90%** ☐ *yes* ☐ ***no***

***NOT ELIGIBLE***
**With no new or increase $O^2$**

**Stable for discharge home:** ☐ *yes* ☐ ***no***

***NOT ELIGIBLE***

**Symptoms**_________________________________________________________________________________

The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) for the emergency use of bebtelovimab for the treatment of mild-to-moderate coronavirus disease 2019 (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, **and**
- or whom alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate.

High risk is defined as a patient who ***meets at least one*** of the following criteria: (check all that apply)

☐ BMI $\geq$ 35 ☐ chronic kidney disease ☐ Diabetes ☐ Immunosuppressive disease
☐ currently receiving immunosuppressive treatment ☐ Are $\geq$ 65 years of age

If eligible on screening criteria of duration, pulse oximetry, outpatient treatment **AND** one or more of

☐ Are $\geq$ 55 years of age **AND** ☐ Cardiovascular disease, **OR** ☐ Hypertension,
**OR** ☐Chronic obstructive pulmonary disease / other chronic respiratory disease

high-risk factors checked above, **patient must have a positive COVID test (either documented prior test or rapid test today)**.

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

**NOT ELIGIBLE**

Positive Test Type: ☐ PCR ☐ Antigen

☐ **Administer Bebtelovimab 175mg IV Push over 30 second's single dose**

**Physician/APP:** ___________________________________ ___________________________________
**Print** **Signature**