OH REFERRAL FOR OUTPATIENT REMDESIVIR THERAPY

Patient Name: _____ Patient's Age _____

Patient's DOB: _____ Patient's Contact Number: _____

***All Questions Must be Answered before Order is Valid* Fax Completed Form to 270-688-2275**

Has patient had a positive Covid-19 test in the past seven (7) days? Yes or No

For patients with mild to moderate Covid-19 symptoms and (Yes) to Positive Covid-19 test what date did the test occur? _____.

Date of symptom onset? _____

<u>If patient has any of the following contraindications then remdesivir isn't a treatment option.</u>

- Less than 12 years of age
- Weight under eighty-eight (88) pounds

<u>Renal dysfunction: (must check box)</u>

There are no formal safety data available for remdesivir use in patients with eGFR < 30mL/min or on dialysis. The manufacturer does not recommend use in these patients. There have been limited case reports of using remdesivir in this clinical scenario.

☐ I acknowledge the lack of safety data available for remdesivir use in patients with eGFR < 30mL/min and in patients who receive dialysis and wish to proceed with remdesivir therapy.

<u>Indications for use: (Check all that apply)</u>

☐ Age ≥ 65 years
☐ Obesity or overweight (BMI > 25 or, for 12-17 years of age, BMI > 85th percentile for age and gender based on CVC growth charts https://www.cdc.gov/growthcharts/clinical_charts.htm)
☐ Pregnant
☐ Chronic kidney disease
☐ Diabetes
☐ Immunosuppressive disease or immunosuppressive treatment
☐ Hypertension or cardiovascular disease (including congenital heart disease)
☐ Chronic lung disease (i.e. COPD, moderate to severe asthma, interstitial lung disease, CF, pulmonary HTN)
☐ Sickle cell disease
☐ Neurodevelopmental disorders (i.e. CP) or other conditions that confer medical complexity (i.e. genetic or metabolic syndromes and severe congenital abnormalities)
☐ Medical-related technological dependence (i.e. tracheostomy, gastrostomy, or positive-pressure ventilation not related to COVID-19)

Has the Patient and/or Caregiver received "Fact Sheet" information in written or verbal form? Yes or No

Has Patient been informed of alternatives to receiving remdesivir therapy? Yes or No

Has the Patient been informed that remdesivir is an unapproved drug that is authorized for use under the Emergency Use Authorization? Yes or No

Provider Printed Name: _____

Provider Signature: _____

<u>By signing above you are authorizing the patient to receive remdesivir based on availability and indications.</u>