Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of screen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_

Address: \_\_

Is patient insured: If yes, please list the following:

Primary insurance name: Subscriber Number:

Policy holder name: Policy holder date of birth:

PATIENTS **MUST BE AT HIGH RISK FOR PROGRESSION TO SEVERE COVID-19 *AND* BE ABLE TO ANSWER YES TO THE FOLLOWING QUESTIONS.**

1. Is patient at least 12 years of age and weighing at least 88 pounds?

Yes\_\_\_ No\_\_\_ **(If “NO”, STOP- patient is not eligible for this treatment.)**

1. Have you tested positive for COVID-19? Yes\_\_\_\_ No\_\_\_\_\_

If “NO”, have you been exposed by close contact criteria\* to an individual infected with COVID-19? Yes\_\_\_\_\_ No \_\_\_\_\_\_ **(If no, STOP- patient is not eligible for treatment)**

**THIS TREATMENT IS NOT FOR PRE-EXPOSURE PROPHYLAXIS OR PREVENTION OF THE VIRUS.**

1. When was the onset of symptoms? (When did symptoms start?) **Must be within the past 10 days.**
2. Patient is not fully vaccinated or is fully vaccinated but is NOT expected to develop an adequate immune response to the virus. Yes\_\_\_\_ No\_\_\_\_\_

**\* THE CDC DEFINES CLOSE CONTACT AS SOMEONE WHO HAS BEEN WITHIN 6 FEET OF AN INFECTED PERSON (LABORATORY CONFIRMED OR CLINICALLY COMPATIABLE ILLNESS) FOR A CUMULATIVE TOTAL OF 15 MINUTES OR MORE OVER A 24 HOUR PERIOD.**

If ***any*** of the following applies to patient, they do not qualify, as treatment is contraindicated.

1. PATIENT IS HOSPITALIZED
2. PATIENT REQUIRES OXYGEN THERAPY FOR DIAGNOSIS OF COVID-19
3. PATIENT REQUIRES AN INCREASE IN BASELINE OXYGEN FLOW RATE DUE TO DIAGNOSIS OF COVID-19 (I.E. PATIENT WAS RECEIVING 2 LITERS OF OXYGEN PRIOR TO DIAGNOSIS BUT NOW REQUIRES 3, ETC.)
4. PREVIOUS SEVERE HYPERSENSITIVITY REACTION TO REGENERON.

\_\_\_\_\_Patient has been screened and meets the requirements for treatment.

 Patient has been scheduled for treatment. Treatment date is: \_\_\_\_\_\_\_.

\_\_\_\_\_ Patient has been screened and does NOT meet the requirements for treatment.

Signature of staff completing the screen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_