VOLUNTEER PHARMACY

REGEN-COV (casirivimab and imdevimab) Questionnaire

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ SSN: _____

Allergies: _____

Emergency Contact Name & Number: _____

Primary Care Provider: _____

Have you been exposed to COVID-19 in the past 10 days: Yes No

Have you tested positive for COVID-19 in the past 10 days: Yes No I have not been tested

FOR COVID^{+} PATIENTS

COVID^{+} test date: _____

Date of symptom onset: _____ (must be < 10 days)

Have you been fully vaccinated for COVID-19: Yes No

If yes, please circle vaccination Manufacturer and dates: Moderna Pfizer J&J

Dates of Vaccinations Dose 1: _____ Dose 2: _____ Dose 3: _____ Booster: _____

Have you had a new onset of any of the following symptoms within the previous 48 hours (*check all that apply)*:

- ☐ Fever or chills
- ☐ Cough
- ☐ Loss of taste or smell
- ☐ Sore throat
- ☐ Body pain or muscle pain/aches
- ☐ Chills
- ☐ Shortness of breath or difficulty breathing
- ☐ Fatigue
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Headache
- ☐ Nasal obstruction/congestion
- ☐ Nasal discharge
- ☐ Other:_____

Select any additional medical conditions or factors listed below *(check all that apply)*:

- ≥65 years of age
- Obesity or overweight (BMI >25kg/m2) or if age 12-17, BMI ≥85th percentile *(based on CDC growth charts)*
- Pregnancy
- Chronic Kidney Disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension
- Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- Sickle cell disease
- Neurodevelopmental disorders (i.e., cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID 19))
- Other: _____

Have you experienced any of the following events in the past 10 days (select all that apply):

- Hospitalization due to COVID-19
- Required oxygen therapy due to COVID-19
- Required an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity
- Had a known hypersensitivity to any ingredient of casirivimab/imdevimab

Consent (check each box below after reading and signing):

☐ I consent to taking pre-treatment medications before receiving REGEN-COV.

____ Acetaminophen (Tylenol) ____ Diphenhydramine (Benadryl) or Cetirizine (Zyrtec)

☐ I agree to stay in the injection administration area for one (1) hour or longer if indicated by the injection administrator after receiving my injections to ensure that no immediate adverse reactions occur.

☐ I understand the risks and benefits of the REGEN-COV subcutaneous injections as described in the Regeneron REGEN-COV Emergency Use Authorization (EUA) Fact Sheet for COVID-19, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the REGEN-COV monoclonal antibody medication to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.

Signature of Person to Receive REGEN-COV (or Signature of Parent/Guardian if Patient is <18 years old)

Signature: _____ Date: _____

Relation to patient <18 years old: _____