BROWARD HEALTH

Bebtelovimab
Injection Order Form

Rx: Bebtelovimab 175 mg IV injection x 1 dose over 30 seconds

Patient: ______________________________ Date: ______________

Date of birth: ______________ Patient contact phone: ______________________

Date of resulted COVID-19 test (PCR or Antigen): ________ Date of onset of symptoms: ________

Is the patient pregnant? YES/NO/UNKNOWN

ADULT AND PEDIATRIC INCLUSION CRITERIA

Patients 12 years of age and older ≥ 40kg with lab-confirmed COVID-19 PLUS one of the following high risk factors ***(must select at least one):***

- ❑ ≥65 years of age
- ❑ Obesity or being overweight (e.g., adults with BMI >25 kg/m2, or if age 12 to 17, BMI ≥85th percentile for age and gender based on CDC growth charts)
- ❑ Pregnancy
- ❑ Chronic kidney disease
- ❑ Diabetes
- ❑ Immunosuppressive disease or immunosuppressive treatment
- ❑ Cardiovascular disease or hypertension
- ❑ Chronic lung disease
- ❑ Sickle cell disease
- ❑ Neurodevelopmental disorders (for example, cerebral palsy)
- ❑ Having a medical-related technological dependence (i.e., tracheostomy, gastrostomy)

ADULT AND PEDIATRIC EXCLUSION CRITERIA

Must select at least one:

- ❑ Body weight < 40 kg
- ❑ Hospitalized patient due to COVID-19
- ❑ Patients requiring oxygen therapy due to COVID-19
- ❑ Patients requiring 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
- ❑ None of the above

I attest that I reviewed the Bebtelovimab EUA Fact Sheet with my patient and provided a copy.

Physician/APRN/PA name: ______________________________

Physician/APRN/PA signature: ______________________________

Fax this order form and prescription to 954.759.7427

Emergency Use Authorization (EUA) is available at www.fda.gov/media/156152/download