William Osler Health System

Going Beyond

[PLACE PATIENT LABEL HERE]

Approval Form for Use of Sotrovimab for COVID-19 Pneumonia

Osler COVID Clinical Response Committee (CCRC) Recommendations:

- Osler supports the use of sotrovimab in patients with **mild illness** as outlined by the Ontario Science Advisory Table. For complete criteria details, please visit https://covid19-sciencetable.ca/
- Sotrovimab will be used in the following patients who meet the inclusion criteria:
  - Outpatients requiring therapy in the Urgent Care Clinic
  - Admitted patients with a nosocomial infection
- For the treatment of mild COVID-19, a **one time dose of 500 mg of sotrovimab** (to be given intravenously) is recommended
- Sotrovimab will be dispensed upon receipt of this completed approval form AND an accompanying order
- Prescribers must dictate a note describing the informed consent discussion and that the patient meets prescribing criteria

CCRC recommends an informed discussion with patients who meet the following criteria for sotrovimab therapy for COVID-19:

Inclusion Criteria ***(Note: All boxes must be checked off)***	**YES**	**NO**
Outpatient treatment **OR** nosocomial COVID-19 infection		
Symptomatic with mild illness[1]		
Confirmed COVID-19 infection		
Symptoms for 7 days or less (Date of Symptom onset_____)		
70 years of age or older **AND** at least one additional risk factor[2] **OR** 50 years and older **AND** First Nations, Inuit, or Métis **AND** have at least one additional risk factor[2]		

[1]Patients not requiring new or increasing supportive oxygen above baseline and not requiring any physiological support.

[2]Risk factors include: obesity (BMI 30 or greater), dialysis or stage 5 kidney disease (eGFR less than 15 mL/min/1.73 m^2), diabetes, cerebral palsy, intellectual disability of any severity, sickle cell disease, receiving active cancer treatment, solid organ or stem cell transplant recipients

Exclusion Criteria ***(Note: All boxes must be checked off)***	**YES**	**NO**
Severe hypersensitivity (e.g. anaphylaxis) to sotrovimab or any component of the formulation		

COMMENTS:

REQUIRED APPROVALS:

	NAME	**SIGNATURE**	**DATE**
Ordering Prescriber*			

This form is to be completed in advance. Maintain a copy of the form along with the order in the chart. Scan the form and the order to Pharmacy.