

Patient Name: _____

DOB: _____

BAMLANIVIMAB INDICATION CHECKLIST

This guide is intended to help inform appropriate prescribing for bamlanivimab in accordance with the Emergency Use Authorization (EUA), document clinical decision making and support medical necessity. **This guide is not intended to supersede guidance from the Food and Drug Administration, state/local health departments, or other regulatory bodies. For complete information, refer to www.bamlanivimab.com**

Criteria for Authorized Use
<input type="checkbox"/> Positive results of direct SARS-CoV-2 viral testing (date of positive test result: _____) Date of symptom onset: _____ Bamlanivimab should be given as soon as possible after a positive test and within 10 days of symptom onset
<input type="checkbox"/> Mild-to-moderate coronavirus disease 2019 (COVID-19) <input type="checkbox"/> Mild coronavirus disease 2019 (COVID-19) <input type="checkbox"/> Signs and symptoms consistent with COVID-19 infection (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell). <input type="checkbox"/> <i>Does not have</i> shortness of breath, dyspnea on exertion, or abnormal imaging. <input type="checkbox"/> Moderate coronavirus disease 2019 (COVID-19) <input type="checkbox"/> Evidence of lower respiratory disease during clinical assessment or imaging <input type="checkbox"/> SpO ₂ ≥94% on room air at sea level
<input type="checkbox"/> Weights at least 40 kg (weight: _____)
<input type="checkbox"/> At high risk for progressing to severe COVID-19 and/or hospitalization due to the following (provide additional info next to criteria, e.g. diagnosis, medication): <input type="checkbox"/> age 65 years or older (age: _____ years) <input type="checkbox"/> body mass index (BMI) ≥35: _____ kg/m ² <input type="checkbox"/> chronic kidney disease, stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> immunosuppressive disease: <input type="checkbox"/> currently receiving immunosuppressive treatment: <input type="checkbox"/> Age 55 years or older (age: _____ years) AND at least one of the following: <input type="checkbox"/> cardiovascular disease: <input type="checkbox"/> hypertension <input type="checkbox"/> chronic obstructive pulmonary disease/other chronic respiratory disease: <input type="checkbox"/> Age 12 - 17 years (age: _____ years) AND at least one of the following: <input type="checkbox"/> BMI ≥85th percentile for age and gender [†] : _____ kg/m ² <input type="checkbox"/> sickle cell disease <input type="checkbox"/> congenital or acquired heart disease: <input type="checkbox"/> neurodevelopmental disorders (e.g. cerebral palsy): <input type="checkbox"/> a medical-related technological dependence [‡] : <input type="checkbox"/> asthma, reactive airway or other chronic respiratory disease that requires daily medication for control:
<input type="checkbox"/> Does not require supplemental oxygen due to COVID-19 (or increase in baseline requirements if on chronic oxygen therapy unrelated to COVID-19)

[†] based on CDC growth charts, available at: https://www.cdc.gov/growthcharts/clinical_charts.htm

[‡] e.g. tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)