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| **CASIM02\_ver1.1 Interim Clinical Commissioning Policy: Casirivimab and imdevimab for patients hospitalised due to COVID-19** | | | |
| **Patient NHS No:** |  | **Trust:** |  |
| **Patient Hospital No:** | \* | **Practice Code:** |  |
| **Patient's Initials and DoB:** |  | **GP Postcode:** |  |
| **Consultant Name:** | \* | **Other Contact Details:** | \* |
| **Notification Email Address:**  (NHSE accredited domains ONLY) | | | |
| **Treatment Start Date:** | |  |  | | --- | --- | |  |  | | | |
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| **Please indicate whether patient meets the following criteria:** | **Please tick** |
| 1. I confirm that the patient is hospitalised with SARS-CoV-2 infection\* and is negative for baseline serum anti-spike (anti-S) antibodies against SARS-CoV-2  \* In the absence of a confirmed virological diagnosis, casirivimab and imdevimab should only be used when a multidisciplinary team have a high level of confidence that the clinical and radiological features suggest that COVID-19 is the most likely diagnosis | |  | | --- | | Yes | | No |   \* Required |
| 2. I confirm one of the following apply (please select):   |  | | --- | | The patient is aged 50 or over | | The patient is aged between 12 to 49 AND determined to be immunocompromised\*\* by multidisciplinary team (MDT) assessment |   \* Required  \*\*Refer to appendix 1 of the interim clinical commissioning policy | |  | | --- | | Yes | | No |   \* Required |
| 3. I confirm the following underlying condition is the reason for which the patient is determined to be immunocompromised:  **(if you have selected 'the patient is aged 50 or over' for Question 2 please select '50 or over' below)**   |  | | --- | | 50 or over | | Down’s syndrome | | Post solid-organ, bone marrow or stem cell transplant | | Primary immunodeficiency | | Secondary immunodeficiency (if not separately included in this list) | | Chemotherapy recipient (groups B and C – refer to policy appendix) | | Sickle cell disease | | CKD stage 5 | | HIV/AIDS | | Liver cirrhosis | | Recipient of radiotherapy in the last 6 months | | Rare neurological conditions | | Other |     Please specify if 'Other': | |  | | --- | | Yes | | No |   \* Required |
| 4. I confirm the patient does not meet any of the exclusion criteria listed in the interim clinical commissioning policy | |  | | --- | | Yes | | No |   \* Required |
| 5. I confirm that the patient will receive one dose of 2.4g (1.2g casirivimab and 1.2g imdevimab) as described in the Specialised Pharmacy Services institutional readiness document\*\*\*  \*\*\* https://www.sps.nhs.uk/home/guidance/covid-19-treatments/neutralising-monoclonalantibodies/casirivimab-and-imdevimab/ | |  | | --- | | Yes | | No |   \* Required |
| 6. I confirm that the patient will receive casirivimab and imdevimab according to the interim clinical commissioning policy\*\*\*\*  \*\*\*\* As part of the policy sites are strongly encouraged to submit data through the ISARIC 4C Clinical Characterisation Protocol (CCP) case report forms (CRFs), as coordinated by the COVID-19 Clinical Information Network (CO-CIN) | |  | | --- | | Yes | | No |   \* Required |