**Appendix 1**

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| **CASIM03\_ver1.1 Interim Clinical Commissioning Policy: Interim Clinical Commissioning Policy: Casirivimab and imdevimab in the treatment of COVID-19 in hospitalised patients – registration form for patients hospitalised due to COVID-19** | | | |
| **Patient NHS No:** |  | **Trust:** |  |
| **Patient Hospital No:** | \* | **Practice Code:** |  |
| **Patient's Initials and DoB:** |  | **GP Postcode:** |  |
| **Choose Consultant:** |  | | |
| **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\*  \* 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 that **one** of the following apply(please select):   |  | | --- | | The patient had a negative test for baseline serum anti-spike (anti-S) antibodies against SARS-CoV-2 | | The patient had a positive/marginal test (within the bottom 10% of the assay’s positive range) for baseline serum anti-spike (anti-S) antibodies against SARS-CoV-2 with a MDT determined treatment decision\*\* | | The patient is immunodeficient and on replacement human immunoglobulin therapy\*\* |   \*\*Refer to the interim clinical commissioning policy with respect to antibody testing and to use in patients on human immunoglobulin treatment | |  | | --- | | Yes | | No |   \* Required |
| 3. I confirm the patient has been hospitalised specifically for the management of acute symptoms of COVID-19 | |  | | --- | | 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\*\*\*  **Note: This is an off-label dose and Trust policy regarding off-label use of medicines should apply**  \*\*\* https://www.sps.nhs.uk/home/guidance/covid-19-treatments/neutralising-monoclonal-antibodies/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 |

**Appendix 2**

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| **CASIM04\_ver1.0 Interim Clinical Commissioning Policy: Interim Clinical Commissioning Policy: Casirivimab and imdevimab in the treatment of COVID-19 in hospitalised patients – registration form for patients with hospital onset 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 in hospital with SARS-CoV-2 infection which has been confirmed by a polymerase chain reaction (PCR) test within the preceding 72 hours or where a multidisciplinary team (MDT) has a high level of confidence that the clinical and/or radiological features suggest that COVID-19 is the most likely diagnosis | |  | | --- | | Yes | | No |   \* Required |
| 2. I confirm the patient was hospitalised for indications other than for the management of acute symptoms of COVID-19 | |  | | --- | | Yes | | No |   \* Required |
| 3. I confirm **one** of the following apply (please select):   |  | | --- | | The patient is at high risk of progression to severe COVID-19 (see Appendix 1 of the interim clinical commissioning policy for list of qualifying conditions) | | COVID-19 infection presents a material risk of destabilising a pre-existing condition or illness or compromising recovery from surgery or other hospital procedure (as determined by multidisciplinary team [MDT] assessment) | | |  | | --- | | Yes | | No |   \* Required |
| 4. I confirm a baseline serum antibody test (anti-S) against SARS-CoV-2 has been taken prior to treatment administration\*  \* All patients being considered for treatment with casirivimab and imdevimab for COVID-19 during their hospital stay should have their baseline serum antibody (anti-S) status measured prior to treatment, with appropriate patient consent, to support service evaluation and surveillance. | |  | | --- | | Yes | | No |   \* Required |
| 5. I confirm the patient does not meet any of the exclusion criteria listed in the interim clinical commissioning policy | |  | | --- | | Yes | | No |   \* Required |
| 6. I confirm that the patient will receive one dose of 1.2g (600mg casirivimab and 600mg imdevimab) as described in the Specialised Pharmacy Services institutional readiness document\*\*  \*\* https://www.sps.nhs.uk/home/guidance/covid-19-treatments/neutralising-monoclonal-antibodies/casirivimab-and-imdevimab/ | |  | | --- | | Yes | | No |   \* Required |
| 7. 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 |