**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 |

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| Yes |
| No |

\* Required |
| 2. I confirm that **one** of the following apply(please select):

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| 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   |

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| Yes |
| No |

\* Required |
| 3. I confirm the patient has been hospitalised specifically for the management of acute symptoms of COVID-19 |

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| Yes |
| No |

\* Required |
| 4. I confirm the patient does not meet any of the exclusion criteria listed in the interim clinical commissioning policy |

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| 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/ |

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| 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) |

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| 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 |

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| Yes |
| No |

\* Required |
| 2. I confirm the patient was hospitalised for indications other than for the management of acute symptoms of COVID-19 |

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| Yes |
| No |

\* Required |
| 3. I confirm **one** of the following apply (please select):

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| 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) |

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| 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. |

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| Yes |
| No |

\* Required |
| 5. I confirm the patient does not meet any of the exclusion criteria listed in the interim clinical commissioning policy |

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| 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/ |

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| 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) |

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| Yes |
| No |

\* Required |