## Bamlanivimab Emergency Use Authorization (EUA) Verification Form

I, _____ (patient or legal guardian please print) verify that the following information has been reviewed with me prior to receiving bamlanivimab infusion per the provisions of the Emergency Use Authorization of bamlanivimab issued by the Food and Drug Administration (FDA) for use in _____ (Patient please print)

❑ I confirm that I do not have any of the following contraindications

- Any known hypersensitivity to any ingredient of the Bamlanivimab
- Are currently hospitalized due to COVID−19
- Require oxygen therapy due to COVID−19
- Require an increase in baseline oxygen flow rate due to COVID−19 in those on chronic oxygen therapy due to underlying non−COVID−19 related comorbidity

❑ I have been given the Fact Sheet for Patients, Parents, and Caregivers (Appendix I of the bamlanivimab policy)

❑ I have been informed of alternatives to receiving bamlanivimab

❑ I have been informed that bamlanivimab is an unapproved drug that is authorized for use under this EUA

_____ _____

Patient / Legal Guardian Date