SOTROVIMAB EMERGENCY USE AUTHORIZATION

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

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

- 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
- Any known severy hypersensitivity to any ingredient of Sotrovimab

❑ The prescribing healthcare practitioner has communicated the information within the Sotrovimab "Fact Sheet for Patients, Parents, or Caregivers," and has provided me with a copy of this Fact Sheet.

❑ I have been informed of alternatives to receiving Sotrovimab

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

_____ _____

Patient / Legal Guardian Date

Account#: **KM0000000**

MR#:

Room/Bed: /

Sex: Age: 0 DOB:

Date of Service:

, , ,

CONSENT

KOOTENAI HEALTH
Coeur d'Alene, Idaho

SOTROVIMAB
EMERGENCY USE AUTHORIZATION

717000-044 Dev. 01/2022