

FORM A: Patient Intake Form

Treating physician or designee should complete this form to provide patient's baseline condition **prior** to tecovirimat initiation. Return to CDC within **3 working days** of initiation of therapy by email (regaffairs@cdc.gov) or upload to secure ShareFile at <https://centersfordiseasecontrol.sharefile.com/r-r3941801ebcbd4002b4dfe98e314ec697>.

HOSPITAL INFORMATION		
Treating Physician Name	Telephone number	Email address
Hospital/Medical Facility Name		Date of assessment (mm/dd/yy):
PATIENT INFORMATION		
Patient Name (first and last name)		Date of Birth
Sex assigned at birth <input type="checkbox"/> M <input type="checkbox"/> F	Gender patient identifies as <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Transgender male <input type="checkbox"/> Transgender female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, weeks of gestation: ____ <input type="checkbox"/> Unknown
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	Race (check all that apply) <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Patient Cell Phone:	Patient Email Address:	Patient has been informed that contact information may be provided to CDC for potential follow-up surveys: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Patient Diary Form given: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
ELIGIBILITY CRITERIA for TECOVIRIMAT TREATMENT		
1. Primary Treatment for Orthopoxvirus Infections <ul style="list-style-type: none"> • Does the patient have laboratory confirmed orthopoxvirus infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • Has the orthopoxvirus species been confirmed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, indicate species: _____ <input type="checkbox"/> Unknown • Date of last exposure: _____ <input type="checkbox"/> Unknown • Reason for tecovirimat treatment: <ul style="list-style-type: none"> <input type="checkbox"/> Risk of severe outcome due to immunosuppression <input type="checkbox"/> Lesions in sensitive anatomical areas <input type="checkbox"/> Pain <input type="checkbox"/> Other, specify: _____ 		
OR		
2. Post-exposure prophylaxis for high-risk contact of a confirmed or probable orthopoxvirus positive case <input type="checkbox"/> Yes <input type="checkbox"/> No ** Note: PEP use is determined on an individual basis in consultation with CDC.** Indicate orthopoxvirus species: _____ Date of last exposure: _____ <input type="checkbox"/> Unknown		
OR		
3. Secondary Treatment for Complications Resulting from Vaccinia Vaccination/Exposure 3a. Has the patient developed vaccine-related complications from being vaccinated with vaccinia vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date of Vaccination: _____		
OR		

3b. Has the patient been exposed to vaccinia virus without vaccination and developed vaccinia-related complications? Yes No Date of last exposure: _____ Unknown

▪ What is the complication? (check one below)

Severe generalized vaccinia (GV),

Describe the extent of lesions and other systemic manifestations of GV:

Eczema vaccinatum

Progressive vaccinia (vaccinia necrosum)

Serious inadvertent inoculation, describe how assessed and systemic findings:

INELIGIBILITY FOR TECOVIRIMAT TREATMENT

1. Unwilling to sign informed consent.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Refuse tecovirimat treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Known allergy to tecovirimat and/or inactive ingredients of tecovirimat.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4. For IV tecovirimat only: patients with severe renal impairment (creatinine clearance <30 mL/min)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

MEDICAL HISTORY

Date of illness onset: <input type="checkbox"/> Unknown	Date of exposure: <input type="checkbox"/> Unknown
Patient started as inpatient or outpatient? <input type="checkbox"/> Inpatient, date of admission: <input type="checkbox"/> Outpatient	Admitted to ICU? <input type="checkbox"/> Yes if yes, date: <input type="checkbox"/> No

Does patient have history of prior smallpox vaccination? Yes No Unknown

• If yes, indicate the vaccine received: ACAM2000 Jynneos Unknown

• Date(s) of vaccination: _____ Unknown

• If vaccinated with ACAM2000, was there a documented vaccine “take”?

Yes No If yes, date of take: _____

Medical History (may attach notes from medical record)

HIV/AIDS

Atopic dermatitis or eczema active historical

Other skin disease, specify: _____ active historical

Congenital/acquired immune defect

Autoimmune/connective tissue disorder

Bone marrow/organ transplant

Leukemia

Lymphoma

Other infection(s); specify: _____

Other cancer; specify: _____

Other pre-existing condition(s); specify: _____

Vital signs (to the extent feasible to be collected)

Patient Weight (kg):	Height (ft. in.):	Pulse (bpm):	Temperature (°F):
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SIGNS/SYMPTOMS ON INITIAL PRESENTATION**Number of lesions**

- < 10 lesions
 10 – 100 lesions
 > 100 lesions

Approximate #: _____

Size of maximal lesion (mm)**Percent of body affected (%)****Lesion photos taken?** Yes Date(s) taken: _____

If yes, send photos to CDC

 No

Clinical Narrative (please describe presenting illness, signs and symptoms, including type, site and circumstances of exposure, and lesion characteristics; may attach electronic summary visit from patient's EHR)

DISTRIBUTION OF LESIONS**Left**

- Scalp Face Mouth Oral mucosa
 Throat Eye Hand Arm
 Trunk Abdomen Buttock Genitals
 Anus Thigh Calf Foot
 Other, specify: _____

Right

- Scalp Face Mouth Oral mucosa
 Throat Eye Hand Arm
 Trunk Abdomen Buttock Genitals
 Anus Thigh Calf Foot
 Other, specify: _____

LIST OF MEDICATIONS

(list all medications, especially any immunosuppressing medications and other antivirals or treatments for orthopoxvirus infection [tecovirimat can be used in conjunction with other therapies based on treating physician's clinical judgment]).

Note: Co-administration of tecovirimat with repaglinide may cause hypoglycemia. Monitor blood glucose and monitor for hypoglycemic symptoms during co-administration. Co-administration with midazolam may reduce concentration of midazolam; monitor effectiveness of midazolam in patients.

Medication	Dosage/Frequency	Administration route	Dates of administration
Tecovirimat		<input type="checkbox"/> Oral <input type="checkbox"/> IV	<input type="checkbox"/> Date first dose taken or <input type="checkbox"/> Date prescribed:

OPTIONAL CLINICAL LABORATORY TESTING

Attach a copy of clinical laboratory results (e.g., hematology, chemistry, urinalysis) if any were performed per treating physician's clinical judgment depending on a patient's underlying clinical conditions to monitor the safety of tecovirimat treatment as appropriate (i.e., baseline, during, post treatment).