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
☐ M ☐ F

Gender patient identifies as
☐ M ☐ F ☐ Transgender male
☐ Transgender female ☐ Other ☐ Unknown

Pregnant
☐ Yes ☐ No ☐ Unknown
If yes, weeks of gestation:____ ☐ Unknown

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race (check all that apply)
☐ African American/Black ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Other ☐ Unknown

Patient Cell Phone:

Patient Email Address:

Patient has been informed that contact information may be provided to CDC for potential follow-up surveys:
☐ Yes ☐ No ☐ Unknown

Patient Diary Form given: ☐ Yes ☐ No ☐ Unknown

ELIGIBILITY CRITERIA for TECOVIRIMAT TREATMENT

1. Primary Treatment for Orthopoxvirus Infections

- Does the patient have laboratory confirmed orthopoxvirus infection? ☐ Yes ☐ No ☐ Unknown
- Has the orthopoxvirus species been confirmed ☐ Yes ☐ No ☐ Unknown
  If yes, indicate species:_____ ☐ Unknown
- Date of last exposure: _____ ☐ Unknown
- Reason for tecovirimat treatment:
  ☐ Risk of severe outcome due to immunosuppression ☐ Lesions in sensitive anatomical areas
  ☐ Pain ☐ Other, specify:_____

OR

2. Post-exposure prophylaxis for high-risk contact of a confirmed or probable orthopoxvirus positive case
☐ Yes ☐ No ** Note: PEP use is determined on an individual basis in consultation with CDC.**

Indicate orthopoxvirus species:_____
Date of last exposure: _____ ☐ 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?
☐ Yes ☐ 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.	☐ Yes ☐ No
2. Refuse tecovirimat treatment.	☐ Yes ☐ No
3. Known allergy to tecovirimat and/or inactive ingredients of tecovirimat.	☐ Yes ☐ No ☐ Unknown
4. For IV tecovirimat only: patients with severe renal impairment (creatinine clearance <30 mL/min)	☐ Yes ☐ No ☐ N/A

MEDICAL HISTORY

Date of illness onset: ☐ Unknown	**Date of exposure**: ☐ Unknown
Patient started as inpatient or outpatient? ☐ Inpatient, date of admission: ☐ Outpatient	**Admitted to ICU?** ☐ Yes if yes, date: ☐ 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):

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				**Right**			
☐ Scalp	☐ Face	☐ Mouth	☐ Oral mucosa	☐ Scalp	☐ Face	☐ Mouth	☐ Oral mucosa
☐ Throat	☐ Eye	☐ Hand	☐ Arm	☐ Throat	☐ Eye	☐ Hand	☐ Arm
☐ Trunk	☐ Abdomen	☐ Buttock	☐ Genitals	☐ Trunk	☐ Abdomen	☐ Buttock	☐ Genitals
☐ Anus	☐ Thigh	☐ Calf	☐ Foot	☐ Anus	☐ Thigh	☐ Calf	☐ Foot
☐ Other, specify: _____				☐ 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		☐ Oral ☐ IV	☐ Date first dose taken **or** ☐ 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).