CONSENT FOR COVID-19 TREATMENT

STORY FAMILY MEDICINE CONSENT FOR COVID-19 TREATMENT

Patient's First Name

Middle Initial

Last Name

Date of Birth

Phone

Email

☐ DISCLAIMER: As your physician has discussed with you, you have been diagnosed with COVID?19 (or SARS?CoV?2). At the present time, there are few Food and Drug Administration (FDA) approved, or clinically proven therapies for treatment of COVID?19. As new clinical data emerges, local treatment guidelines have been developed and will be updated as new information becomes available. CDC guidelines reflect what is known about therapies that may work against the SARS?CoV?2 virus, have been used to treat other coronaviruses, or may theoretically target the underlying causes of virus? related severe lung conditions that make breathing difficult. The FDA has granted Emergency Use Authorization (EUA) to permit investigational therapies in patients with confirmed COVID?19. Investigational therapies are not approved for any indication. They are authorized only for the duration of the declaration that circumstances exist justifying the authorization of the emergency use under section 564(b)(1) of the Act, 21 U.S.C. § 360bbb?3(b)(1), unless the authorization is terminated or revoked sooner. If checked below and signed, you consent to the use under this authorization.

☐ TO PROVIDE TREATMENT: In order for you to be treated with the therapy, you must sign this form to show that you agree to the use of investigational or off label treatments, that you have been informed of the benefits and risks of taking such therapies as well as the benefits and risks of declining or refusing such use. You will be provided a patient informational handout regards the specific medication. You have the right to refuse to take this treatment(s) for any reason.

☐ POSSIBLE BENEFITS: It is possible that the medication may help to control your symptoms, slow or stop the growth of the virus, shorten the duration or lessen the severity of the illness in you. Possible benefits primarily include improvement in lung function (ability to breathe without assistance) and normalization of blood pressure. However, there is the possibility that this medication may be of NO direct medical benefit to you. Your condition may get worse.

☐ POSSIBLE RISKS AND KNOWN SIDE EFFECTS: It is possible that the medication prescribed may not improve your symptoms and not shorten the duration nor severity of the illness. It is possible that the medication will unexpectedly interfere with your ability to improve, hasten damage to the lungs or other organs, and shorten your life. Liver Problems. Tell your healthcare provider right away if you have any of these signs and symptoms of liver problems: loss of appetite, yellowing of your skin and the whites of eyes (jaundice), dark-colored urine, pale colored stools and itchy skin, stomach area (abdominal) pain. Resistance to HIV Medicines. If you have untreated HIV infection, PAXLOVID may lead to some HIV medicines not working as well in the future. Other possible side effects include: altered sense of taste, diarrhea, high blood pressure, muscle aches

☐ ALERTNATIVES: There are no approved alternatives to PAXLOVID for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. Other therapeutics are currently authorized for the same use as PAXLOVID. For additional information on all products authorized for treatment or prevention of COVID-19, please discuss with your medical provider.

☐ I CONSENT FOR TREATMENT: I have read this informed consent form and all of my questions have been answered to my satisfaction by my physician. I understand that I have the right to refuse to take this medication(s) for any reason. If I choose not to take this medication(s), this decision will not otherwise affect my status as a patient. I voluntarily consent to take the medication as discussed.

Date of Consent

Patient Signature
