Maricopa County

MARICOPA COUNTY DEPARTMENT OF PUBLIC HEALTH

PROVIDER CONFIRMATION FOR ORDERING TECOVIRIMAT (TPOXX)

This form must be signed by the treating medical provider when ordering TPOXX from the Maricopa County Department of Public Health Pharmacy. TPOXX will not be dispensed by the MCDPH Pharmacy without a valid prescription and without this form. Providers may include this form with the prescription order, or FAX to 602 506-5078.

1. **As the treating medical provider for _____ (Patient Name), I have received the appropriate Patient Informed Consent Form. Patient Informed Consent Form is to be obtained prior to treatment. The Patient Informed Consent Form has been reviewed, completed, and will be maintained in the patient's medical chart. Provide a copy to the patient. A copy does not need to be returned to CDC.**

   Acknowledgement _____ (Provider initials)

2. **I understand that as the treating medical provider, I must complete the following forms and forward the completed forms to the Centers for Disease Control (CDC) after initiating TPOXX treatment with 3 working days of TPOXX initiation:**
   a. **Patient Intake Form (Attachment 2 – Form A, IND Protocol)**
   b. **FDA Form 1572 (One signed 1572 per facility suffices for all TPOXX treatments administered under the EA-IND at the same facility)**

   Acknowledgement _____ (Provider initials)

3. **I understand that as the treating medical provider, I must complete the Clinical Outcome Form (Attachment 2 – Form B) on last patient's follow -up and forward the completed form to the CDC within 3 working days of last patient's follow-up.**

   Acknowledgement _____ (Provider initials)

4. **As the treating medical provider, if there are any adverse event(s) occurring during treatment with TPOXX, I understand that I must complete an Adverse Event Form (Attachment 6) and forward it to the Centers for Disease Control with 72 hours of awareness or sooner if possible.**

   Acknowledgement _____ (Provider initials)

_____ _____

Signature – Treating Medical Provider Date

_____

Printed Name of Treating Medical Provider

Date revised: July 22, 2022