CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

ORAL TECOVIRIMAT (TPOXX) REQUEST& DATA COLLECTION FORM

Purpose

The purpose of this form is to i.) standardize oral tecovirimat resource requests, and, ii.) to facilitate monthly data collection. The data requested will be used to meet ASPR reporting requirements for inventory, administration and submission of required regulatory forms.

Requests for IV tecovirimat should be sent through Salesforce as usual or to: mpxtreatment@cdph.ca.gov.

For the latest information for TPOXX providers, see: Information for Healthcare Providers on Obtaining and Using TPOXX (Tecovirimat) for Treatment of Monkeypox | Monkeypox | Poxvirus | CDC

Instructions

(Form Must Be Typed. Handwritten forms will not be accepted. A survey link may be provided in the future.)

- Complete all sections of the form when placing orders.
    - For MHOACs: Attach the completed form to the Salesforce request.
- RDMHS/MHOACs: For providers that have not placed an order by the first of each month, monthly data collection is still necessary. Please send the form to these providers and request completion of “Submission Date” and “TPOXX Data” within the first 5 calendar days monthly. Submit completed form to mpxtreatment@cdph.ca.gov.
- Providers are encouraged to estimate and order a three-week supply. For orders greater than 20 treatment courses, please indicate brief justification in the Notes section below (e.g., the number of new patient starts per week for the last 3 weeks.) Requests will be reviewed and quantity adjustments may be made by CDPH upon receipt of the request.
- Form submission:
    - MHOACs: Attach completed forms in Salesforce. For data submission only, email the form as described above.
    - Other requesters: Email completed forms to mpxtreatment@cdph.ca.gov.

TPOXX Receiving Facility Information

Date Submitted		❒ New Site ❒ FDA Form 1572 submitted to CDC on _________ (date)			❒ Current Site	
Site Name:						
Street Address:		City:		Zip Code:		
Delivery location (e.g. inpatient pharmacy)						
Site Contact Name #1:		Title:				
Phone Number:		Email Address:				
Site Contact Name #2:		Title:				
Phone Number:		Email Address:				

Days and Times Receiving Facility Address is/is not Available for Delivery: ______________________________

TPOXX Data and Resource Request

PRODUCT	TPOXX Data				Resource Request
	# Total Patients started to-date	# Total Form A submitted to CDC	Current Inventory (# Bottles)	Total received to date (# Bottles)	Request* (# Bottles)
Tecovirimat® (TPOXX-Oral) Courses = 2 Bottles					

☐ **Resource request is for LHJ/Public Health Pre-positioning for urgent needs**

Requester Notes:

* If requesting more than 20 oral treatment courses, include a brief justification in the Requester Notes section, e.g., the number of patients treated per week for the last 3 weeks or other justification.

Multicounty Tecovirimat Providers

Are you requesting tecovirimat as a multicounty provider? If yes, please list the locations where tecovirimat treatment is being provided in the chart below.

Clinic Name	Address