Infusion Solutions Inc.
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# COVID-19 Monoclonal Antibody Treatment Order Form

****COMPLETE ALL FIELDS TO AVOID TREATMENT DELAYS****

**Patient Information:** Patient Name:_____ DOB:_____ SS#:_____

Insurance Company: _____ Group ID:_____ Member ID:_____

Address: _____ City:_____ State: _____ Zip:_____

Phone: _____ ❑Male ❑Female Ht:_____ in/cm Wt: _____ lb/kg

Allergies: ❑NKDA ❑_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

*****Please fax with order form**: • Current medication list • Copy of insurance card

**Diagnoses:** ❑ COVID-19 Virus, Identified (REQUIRED) ICD-10: U07.1

Therapy should be initiated ASAP after positive test, and within 10 days of symptom onset.

Date of symptom onset: _____ COVID Positive Result Date:_____

COVID vaccination status: ❑Vaccinated (date of final dose): _____ ❑Unvaccinated

**Eligibility:**

Exclusion Criteria (If patient meets any of the following, they are not eligible for treatment):

- ❑ Currently hospitalized due to COVID-19
- ❑ Requires new or increased oxygen therapy due to COVID-19

Inclusion Criteria:

- ❑ Patients must be >=12 years old (Age:_____), AND weigh >= 40 kg (Wt:_____ kg), AND be at high risk for progressing to severe COVID-19 or hospitalization.

Factors which place this patient at higher risk (check all that apply):

- ❑ Older age (ie: >=65 years old) ❑ Overweight/obese (ie: BMI>25, or pediatrics >85$^{th}$%)
- ❑ Pregnancy ❑ Chronic Kidney Disease ❑ Diabetes
- ❑ Immunosuppressive Disease or Treatment ❑ Cardiovascular disease or hypertension
- ❑ Chronic lung disease ❑ Sickle cell disease ❑ Neurodevelopmental disorder
- ❑ Medical-related technological dependence
- ❑ Other (please specify): _____

**Medication Orders:** *Pharmacist to choose brand based on availability. If you prefer to prescribe one or the other, please cross out the brand you do **not** want to prescribe (this may cause a treatment delay).

- ☒ ***Casirivimab and Imdevimab** (REGEN-COV): 600 mg / 600 mg IV x 1 dose
  Directions: Infuse IV over 20-50 minutes per manufacturer guidelines.
- ☒ ***Bamlanivimab and Etesevimab:** 700 mg / 1.4 gm IV x 1 dose
  Directions: Infuse IV over 21-60 minutes per manufacturer guidelines.
- ☒ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ☒ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ☒ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ☒ Infusion Reaction Management per Infusion Solutions protocol as needed.

**Nursing Orders:**

- ☒ RN to insert peripheral IV or access existing central catheter.
- ☒ RN to observe patient for 1 hour post-infusion.

_____ _____

*Prescriber Signature* *Date*

_____

*Please Print Name*

Infusion Solutions Use Only:

- ☐ Pt notified of EUA status & right to decline treatment
- ☐ RPh counsel offered
  Initials _____ Date_____