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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 >85th%)
- ❑ 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/route based on availability and current guidelines. If needed, 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, or inject subcutaneously, 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.
- ☒ ***Sotrovimab:** 500 mg IV x 1 dose
  Directions: Infuse IV over 30 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.
- ☒ 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_________