

107268

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Monoclonal Antibodies for COVID 19
FAX orders to WAR Pharmacy at: 304-258-7431

ALLERGIES	
Weight in Kilograms	Height
DIAGNOSIS: COVID-19 STATUS: OUTPATIENT HCPCS Codes: Q0222 (drug), M0222 (admin)	
Emergency Use Authorization	
For non-hospitalized patients, not on oxygen or without an increase in home oxygen flow rate	
FORM MUST BE COMPLETED IN ENTIRETY OR ORDER WILL BE REJECTED	
1. POSITIVE SARS-CoV-2 test: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____	
2. DATE OF SYMPTOM ONSET (Must be within 7 days): _____	
3. ***REASON for NOT prescribing 1st line drug nirmatrelvir/ritonavir (Paxlovid):	
<input type="checkbox"/> ABSOLUTE drug interaction contraindication List drug(s): _____ <input type="checkbox"/> eGFR less than 30 ml/min (Including dialysis patients)	
4. Vaccination Status: <input type="checkbox"/> 2-Dose Pfizer or Moderna <input type="checkbox"/> J&J <input type="checkbox"/> Booster/3 rd /4 th dose <input type="checkbox"/> Unvaccinated	
5. Code Status: <input type="checkbox"/> Full Code or <input type="checkbox"/> No CPR – Support OK <input type="checkbox"/> No CPR – Allow Natural Death	
6. High Risk Criteria (Please check all that apply):	
<input type="checkbox"/> Body mass index (BMI) greater or equal to 30 BMI: _____	
<input type="checkbox"/> Chronic kidney disease, stages 3 to 5	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Currently receiving immunosuppressant treatment– chemotherapy, immunotherapy, prednisone 20 mg daily or equivalent, OR have chronic immunosuppressive disease	
<input type="checkbox"/> Age 65 years or greater	
<input type="checkbox"/> Cardiovascular disease or hypertension	
<input type="checkbox"/> Chronic lung disease	
<input type="checkbox"/> Sickle cell disease	
<input type="checkbox"/> Neuro-developmental disorders (ex. Cerebral palsy)	
<input type="checkbox"/> Pregnancy: Weeks: _____	
Date: _____ Time: _____ Physician Phone Number: _____	
Physician Signature: _____	
Physician Name (Print): _____	

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Pharmacy may auto-substitute the antibody medication/route based on availability or variants <input type="checkbox"/> Bebtelovimab 175 mg/2 mL IV injected over 30 seconds using a syringe extension set	
Obtain vital signs prior to the injection/infusion and at the end of the injection/infusion <ul style="list-style-type: none"> ● Monitor the patient for any signs of an anaphylactic reaction. Stop the injection/infusion if any of the following occur: Fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, or dizziness ● Monitor the patient for one hour after the end of the injection/infusion 	
For allergic/anaphylactic reactions	
<ul style="list-style-type: none"> ● Stop the injection/infusion and notify the MERT team ● Epinephrine 0.3 mg (1mg/ml) IM x 1 dose as needed for anaphylaxis (see above anaphylactic reaction signs) ● Diphenhydramine (Benadryl) 25 mg IV or PO X 1 dose for itching, swelling, or rash ● Famotidine (Pepcid) 40 mg IV x 1 dose for itching, swelling, or rash ● Methylprednisolone (Solu-Medrol) 125 mg IV x 1 dose for itching, swelling, or rash ● Albuterol sulfate (Proventil) 2 puffs inhaled every 10 minutes up to 3 doses for wheezing, bronchospasm ● If a reaction occurs, document in EPIC, complete risk report, and notify pharmacy 	
7. <input type="checkbox"/> Copy of Insurance Card (front and back) attached in case prior authorization required	
Provider to Complete:	
8. <input type="checkbox"/> Risks and benefits discussed with patient and obtain informed consent	
9. <input type="checkbox"/> Patient Information Sheet provided to patient/caregiver	
Date: _____ Time: _____ Physician Phone Number: _____	
Physician Signature: _____	
Physician Name (Print): _____	