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**Monoclonal Antibodies for COVID 19**  
**FAX orders to HMH Pharmacy at: 304-822-4965**

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

## Monoclonal Antibodies for COVID 19

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<b>Weight in Kilograms</b>	<b>Height</b>
<b>DIAGNOSIS:</b> COVID-19	<b>STATUS:</b> OUTPATIENT
<b>Pharmacy may auto-substitute the antibody medication/route based on availability or variants</b> <input type="checkbox"/> Bebtelovimab 175 mg/2 mL IV injected over 30 seconds using a syringe extension set	
<b>Obtain vital signs prior to the injection/infusion and at the end of the injection/infusion</b> <ul style="list-style-type: none"> <li>● <b>Monitor</b> the patient for any signs of an <b>anaphylactic reaction</b>. 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</li> <li>● <b>Monitor</b> the patient for <b>one hour after</b> the end of the injection/infusion</li> </ul>	
<b>For allergic/anaphylactic reactions</b>	
<ul style="list-style-type: none"> <li>● Stop the injection/infusion and notify the MERT team</li> <li>● Epinephrine 0.3 mg (1mg/ml) IM x 1 dose as needed for anaphylaxis (see above anaphylactic reaction signs)</li> <li>● Diphenhydramine (Benadryl) 25 mg IV or PO X 1 dose for itching, swelling, or rash</li> <li>● Famotidine (Pepcid) 40 mg IV x 1 dose for itching, swelling, or rash</li> <li>● Methylprednisolone (Solu-Medrol) 125 mg IV x 1 dose for itching, swelling, or rash</li> <li>● Albuterol sulfate (Proventil) 2 puffs inhaled every 10 minutes up to 3 doses for wheezing, bronchospasm</li> <li>● If a reaction occurs, document in EPIC, complete risk report, and notify pharmacy</li> </ul>	
<b>7. <input type="checkbox"/> Copy of Insurance Card (front and back) attached in case prior authorization required</b>	
<b>Provider to Complete:</b>	
<b>8. <input type="checkbox"/> Risks and benefits discussed with patient and obtain informed consent</b>	
<b>9. <input type="checkbox"/> Patient Information Sheet provided to patient/caregiver</b>	
<b>Date:</b> _____ <b>Time:</b> _____ <b>Physician Phone Number:</b> _____	
<b>Physician Signature:</b> _____	
<b>Physician Name (Print):</b> _____	