

197268

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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
Emergency Use Authorization	
For non-hospitalized patients not on oxygen or without an increase in home oxygen flow rate	
POSITIVE SARS-CoV-2 test: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____	
DATE OF SYMPTOM ONSET (Must be within 10 days): _____	
VACCINATION STATUS: <input type="checkbox"/> 2-Dose Pfizer or Moderna <input type="checkbox"/> J&J <input type="checkbox"/> Booster/3 rd dose <input type="checkbox"/> Unvaccinated	
Code Status: <input type="checkbox"/> Full Code or <input type="checkbox"/> No CPR – Support OK <input type="checkbox"/> No CPR – Allow Natural Death	
High Risk Criteria (Please check all that apply):	
<input type="checkbox"/> Body mass index (BMI) greater or equal to 35 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	
<input type="checkbox"/> Pregnancy	
Provider to Complete:	
<input type="checkbox"/> Risks and benefits discussed with patient and obtain informed consent	
<input type="checkbox"/> Patient Information Sheet provided to patient/caregiver	
Date: _____ Time: _____ Physician Phone Number: _____	
Physician Signature: _____	
Physician Name (Print): _____	

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ALLERGIES	
Weight in Kilograms	Height
DIAGNOSIS: COVID-19	STATUS: OUTPATIENT
<p>Pharmacy may auto-substitute the antibody medication/route based on availability or variants</p> <ul style="list-style-type: none"> <input type="checkbox"/> Casirivimab 600 mg/Imdevimab 600 mg (Regen-COV) SQ 10 ml (4 SQ injections of 2.5 ml) <input type="checkbox"/> Casirivimab 600 mg/Imdevimab 600 mg (Regen-COV) IV in 100 ml 0.9% Normal Saline to be infused over 21 minutes. Infusion requires the use of a PVC infusion set with a 0.20 or 0.22 micron in-line filter <input type="checkbox"/> Bamlanivimab 700 mg/Etesevimab 1400 mg IV in 50 ml 0.9% Normal Saline to be infused over 21 minutes. Infusion requires the use of a PVC infusion set with a 0.20 or 0.22 micron in-line filter <input type="checkbox"/> Sotrovimab 500 mg IV in 100 ml 0.9% Normal Saline to be infused over 30 minutes. Infusion requires the use of a PVC infusion set with a 0.20 or 0.22 micron in-line filter 	
<p>For SQ administration</p> <ol style="list-style-type: none"> 1. Administer the subcutaneous injections consecutively, each at a different injection site, into the thigh, back of the upper arm, or abdomen, except for 2 inches (5 cm) around the navel. <p>The waistline should be avoided.</p>	
<p>For IV administration</p> <ul style="list-style-type: none"> • After the infusion is complete, flush the line with 50 ml of 0.9% Sodium Chloride IV 	
<p>Obtain vital signs prior to the injection/infusion and at the end of the injection/infusion</p> <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 	
<p>For allergic/anaphylactic reactions</p> <ul style="list-style-type: none"> • Stop the injection/infusion and notify the rapid response 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 	
<p>Date: _____ Time: _____ Physician Phone Number: _____</p>	
<p>Physician Signature: _____</p>	
<p>Physician Name (Print): _____</p>	