017268

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ValleyHealth
Winchester Medical Center

Monoclonal Antibodies for COVID 19

EMAIL orders to antibodies@valleyhealthlink.com (WMC only)

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**: □ **YES** □ **NO** **DATE:** _____
2. **DATE OF SYMPTOM ONSET (Must be within 7 days):** _____
3. *****REASON for NOT prescribing 1st line drug nirmatrelvir/ritonavir (Paxlovid):**

   □ **ABSOLUTE** drug interaction contraindication **List drug(s):** _____

   □ eGFR less than 30 ml/min (Including dialysis patients)
4. **Vaccination Status:** □ **2-Dose Pfizer or Moderna** □ **J&J** □ **Booster/3rd/4th dose** □ **Unvaccinated**
5. **Code Status:** □ **Full Code** or □ **No CPR – Support OK** □ **No CPR – Allow Natural Death**
6. **High Risk Criteria (Please check all that apply):**

   ☐ Body mass index (BMI) greater or equal to 30 **BMI:** _____

   ☐ Chronic kidney disease, stages 3 to 5

   ☐ Diabetes

   ☐ Currently receiving immunosuppressant treatment– chemotherapy, immunotherapy, prednisone 20 mg daily or equivalent, OR have chronic immunosuppressive disease

   ☐ Age 65 years or greater

   ☐ Cardiovascular disease or hypertension

   ☐ Chronic lung disease

   ☐ Sickle cell disease

   ☐ Neuro-developmental disorders (ex. Cerebral palsy)

   ☐ 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

☐ 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

- **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

- 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. ☐ Copy of Insurance Card (front and back) attached in case prior authorization required

Provider to Complete:

8. ☐ Risks and benefits discussed with patient and obtain informed consent

9. ☐ Patient Information Sheet provided to patient/caregiver

Date: _____ **Time:**_____ **Physician Phone Number:** _____

Physician Signature: _____

Physician Name (Print): _____