COVID 19 Outpatient Monoclonal Therapy Order Set

Date: _____ Patient Name: _____

Diagnosis: COVID-19 (ICD-10 UO7.1)____ Date of Birth: _____

Allergies: _____ Patient Contact Number: _____

Medical Record Number: _____ Payor/Plan: _____

Provider Name/Contact Number: _____

Infusion Center Preferred Location:

____Atrium Medical Center Compton Infusion Center (Monday – Friday) (Must Chose this location for patients requiring a stretcher)

____Miami Valley Hospital Infusion Center (Seven Days a Week) (Can accommodate patients requiring stretchers)

____Upper Valley Medical Center Infusion Center (Monday – Friday)

____First Available

Orders for Monoclonal Antibodies for COVID-19 should be faxed to 937-223-9837

Date of Symptom Onset: _____

Date of Positive Test Result: _____

To be eligible for infusion patients must meet ALL criteria in section 1 and a minimum of one criterion in section 2.

Section 1: Please confirm patients meet all criteria (check all that apply)

____Patient has mild to moderate symptoms of COVID 19 with first positive test for SARS-CoV-2 virus and onset of symptoms within past 7 days.

____Patient weighs at least 40 kg and is 12 years of age or older

____ Patient does not require oxygen therapy due to COVID-19 or an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

____Patient has not received prior dose of casirivimab / imdevimab OR bamlanivimab / etesevimib OR sotrovimab

____Patient has not had a previous diagnosis of COVID 19 infection within the past 180 days

Section 2: Must meet at least one of the following criteria (check all that apply)

___Greater than or equal to 65 years of age

___Body Mass Index (BMI) greater than or equal to 35

___Chronic Kidney Disease (Stage III or greater)

___Diabetes with A1C ≥ 8 or random blood sugar > 300 mg/dL

___Pregnant

___Immunosuppressive Condition (solid organ transplant, ESRD or ESLD, advanced HIV, active chemotherapy, chronic high dose steroids (>30mg prednisone for >30 days), use of biologic agents for treatment of underlying diseases (i.e., TNF alpha inhibitor for RA or Crohn's)

___Cardiovascular disease other than hypertension

___Currently receiving treatment with medication for hypertension

___Chronic Obstructive Pulmonary Disease, Interstitial Lung Disease, Cystic Fibrosis, ~~or~~ Pulmonary Fibrosis, or Chronic Asthma

___ I have documented in the patient's medical record that the Fact Sheet for patients was discussed with/given to the patient or caregiver, the patient was informed of alternatives to receiving authorized monoclonal antibodies, and that monoclonal antibodies are unapproved drugs authorized for use under this emergency use authorization.
Patient will also receive the fact sheet when they arrive at the infusion center.

Premier Health

Patient Name:_____, _____ _____
LAST FIRST MIDDLE

Allergies: _____

Date: ____/____/____ Time: _____ **Place Patient Label Here**

Procedure Scheduled for: ___/___/____ At: _____

SYSTEM COVID-19 MONOCLONAL THERAPY (12014) [12014]

NURSING

NURSING - VITAL SIGNS (System COVID-19 Monoclonal Therapy)

☑ Vital Signs baseline, then 5 minutes after infusion has started, then every 30 minutes	Routine, AS NEEDED
☑ Vital Signs Immediately following completion of infusion and then 30 minutes post infusion x 2	Routine, AS NEEDED

NURSING - NURSING ORDERS (System COVID-19 Monoclonal Therapy)

☑ Observe for Hypersensitivity within the first 5 minutes and 1-hour post infusion	Routine, AS NEEDED, Starting S
☑ Discontinue IV	Routine, ONCE, Starting S at 6:00 AM For 1 Occurrences
☑ Discharge Patient	Routine, ONCE, Starting S at 6:00 AM For 1 Occurrences

MEDICATIONS

INFUSION MEDICATIONS (System COVID-19 Monoclonal Therapy) (Single Response) (Selection Required)

Monoclonal Antibody Infusion (Emergency Use Authorization)

- Must be administered within 7 days of onset of symptoms
- Discontinue infusion for severe reaction (shortness of breath, hypotension, hypertension, dyspnea, wheezing or stridor).

NOTIFY PHYSICIAN IMMEDIATELY

◉ casirivimab-imdevimab (REGEN-COV) 1200 mg IV infusion	1,200 mg, Intravenous, for 21 Minutes, ONCE For 1 Doses
○ If casirivimab-imdevimab unavailable utilize bamlanivimab 700 mg and etesevimab 1400 mg	Intravenous, for 31 Minutes, ONCE

SALINE FLUSH WITH CARRIER FLUID (System COVID-19 Monoclonal Therapy)

☑ Insert saline lock	Routine, ONCE, Starting S For 1 Occurrences
☑ Flush saline lock PRN	IV Push, PRN-AS NEEDED
☑ Discontinue saline lock on discharge	Routine, ONCE, Starting S For 1 Occurrences
☑ CARRIER FLUID - Use if continuous IV not infusing	
☑ 0.9% NaCl at 10 mL/hour continuous IV PRN	1,000 mL, Intravenous, CONTINUOUS PRN, at 10 mL/hr, other

REACTION MEDICATIONS (System COVID-19 Monoclonal Therapy)

☑ Mild / Moderate Reaction	
☑ Pause the infusion for fever, chills, nausea, headache, rash including uriticaria, pruritus, myalgia or dizziness and call provider for further instructions	Routine, ONCE, Starting S at 6:00 AM For 1 Occurrences, Pause the infusion for fever, chills, nausea, headache, rash including uriticaria, pruritus, myalgia or dizziness and call provider for further instructions
☑ Severe / Anaphylactic Reaction	
☑ Turn off the infusion for angioedema, shortness of breath, hypotension, dyspnea, wheezing or stridor, administer IM epinephrine, and call provider for further instructions	Routine, ONCE, Starting S at 6:00 AM For 1 Occurrences, Turn off the infusion for angioedema, shortness of breath, hypotension, dyspnea, wheezing or stridor, administer IM epinephrine, and call provider for further instructions
☑ Reaction Medications	**"And" Linked Panel**
☑ EPINEPHrine (ADRENALIN) 0.3 mg IM every 5 mins PRN severe or anaphylactic reaction (up to 3 doses)	0.3 mg, Intramuscular, PRN-AS NEEDED For 3 Doses, other, severe or anaphylactic reaction
☑ methylPREDNISolone (SOLU-Medrol) 125 mg IV once PRN severe or anaphylactic reaction	125 mg, IV Push, ONCE PRN, severe or anaphylactic reaction
☑ diphenhydrAMINE (BENADRYL) 50 mg IV once PRN severe or anaphylactic reaction	50 mg, IV Push, ONCE PRN, severe or anaphylactic reaction
☑ famotidine (PEPCID) 20 mg IV once PRN severe or anaphylactic reaction	20 mg, IV Push, ONCE PRN, severe or anaphylactic reaction
☑ albuterol (PROVENTIL) 90 mcg/actuation inhalation aerosol	2 Puff, Inhalation, ONCE PRN, Shortness of Breath, continued shortness of breath following administration of epinephrine IM

_____

_____

_____

Signature _____

Printed Physician Name: _____

Sent to Pharmacy _____(intials/date/time)

HUC _____ Date/Time

RN _____ Date/Time