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) (Can accommodate patients requiring stretchers)
____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 Casirivimab and Imdevimab Infusion should be faxed to 937-223-9837

Confirm: Patient has mild to moderate symptoms of COVID 19* with first positive result for SARS-CoV-2 virus and onset of symptoms within past 10 days, weighs at least 40 kg, is 18 years of age or older, 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, and has not received prior dose of casirivimab and imdevimab or bamlanivimab.

Yes or No

***Casirivimab and Imdevimab Infusion is not for asymptomatic patients**

Date of Symptom Onset: ____________________________
Date of Positive Test Result: _________________________
If yes, then patient must meet the following criteria to receive Casirivimab and Imdevimab Infusion

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
___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)
Are greater than or equal to 55 years of age with one or more of the following:
___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 casirivimab and imdevimab, and that casirivimab and imdevimab is an unapproved drug that is authorized for use under this emergency use authorization.

Patient will also receive the fact sheet when they arrive at the infusion center.

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)

☑ Must be infused within 10 days of onset of symptoms	Routine, ONCE, Starting S at 6:00 AM For 1 Occurrences
☑ Observe for Hypersensitivity within the first 5 minutes and then 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)

◉ casirivimab 1,200 mg + imdevimab 1,200 mg (REGENERON COCKTAIL) in NaCl 0.9% IV infusion	Intravenous, for 60 Minutes, ONCE For 1 Doses

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

Order	Details
☑ 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

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Signature ______________________________________

Printed Physician Name: ______________________________

Sent to Pharmacy ________________________(intials/date/time)

HUC ____________________ Date/Time

RN ____________________ Date/Time