FAX or EMAIL PATIENT STICKER

SUBJECT: COVID-19 Monoclonal Antibody Infusion Order
TO: Comanche County Memorial Hospital Infusion Services
FAX: (580) 585-5472
ADDRESS: 3126 NW Arlington Blvd Lawton, OK 73505
EMAIL: infusion@ccmhhealth.com
PHONE: (580) 355-8699 Option 1, Ext 4756 or Ext. 6194 for Scheduling

FORMS MUST BE COMPLETE (NO BLANKS) AND SIGNED BY THE PROVIDER FOR THE PATIENT TO BE CONSIDERED FOR Monoclonal Antibody Infusion

PLEASE PRINT

DATE:_____ **VACCINATION STATUS:**_____
PATIENT NAME:_____ **DOB:**_____
PHONE:_____ **HEIGHT (inches):**_____**INCHES** **WEIGHT:**_____**KG (at least 3kg)**
ALLERGIES:_____
DIAGNOSIS CODE:_____ **DIAGNOSIS NAME (REQUIRED)**_____
PROVIDER NAME (PRINT LAST & FIRST):_____
PROVIDER OFFICE PHONE#_____ **OFFICE FAX #**_____
CONTACT PERSON AT PROVIDER OFFICE:_____

SARS-CoV-2 Specific Monoclonal Antibody Guidelines

● FDA approval has been expanded the indication for Veklury (remdesivir) to include its use in adults and pediatric patients (28 days of age and older who weigh at least 3 kilograms) with positive results of direct SARS-CoV-2 viral testing, and who are not hospitalized and have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death.

Provider fact sheet:

Remdesivir provider fact sheet available at: HIGHLIGHTS OF PRESCRIBING INFORMATION These highlights do not include all the information needed to use VEKLURY safely and effec & EUA 046 Veklury (remdesivir) FS for HCPs (01212022)

Before ordering for active infection, review criteria for Paxlovid (also check for drug interactions) and prescribe Paxlovid if the patient is eligible. **Paxlovid (nirmatrelvir and ritonavir tablets) – Medication safety consideration**

If Paxlovid is contraindicated then continue through decision guide found here:

Covid-19 otpt therapeutics decision guide Dec 22.PNG

Covid-19 Pediatric otpt therapeutics decision guide Dec 22.PNG

SARS-CoV-2 Active infection Remdesivir CRITERIA FOR USE

☐ Symptom Onset Date: _____ ☐ Positive COVID-19 test date_____

Patients must meet **ALL** criteria to be eligible

☐ at least 28 Days of age and weighing at least 3 kg

☐ COVID-19 positive by PCR or Antigen testing

☐ **Within 7 days of symptom onset**

☐ Meets all of the following requirements:

- at high risk for progressing to severe COVID-19 and/or hospitalization
- is NOT hospitalized,

☐ **High risk - defined as meeting one or more of the following criteria (select all that apply):**

☐ Body Mass Index (BMI > 25) ☐ Cardiovascular disease ☐ Chronic Kidney Disease
☐ Hypertension ☐ Diabetes ☐ COPD/other chronic respiratory disease ☐ Immunosuppressive Disease
☐ Pregnancy ☐ Medical related technology dependence e.g., gastrostomy)
☐ Receiving immunosuppressive treatment ☐ Sickle cell disease (e.g., gastrostomy)
☐ Age ≥ 65 years
☐ Neurodevelopmental disorders or other conditions that confer medical complexity(e.g., genetic, or metabolic syndrome)

☐ **Patient or caregiver received a copy of the patient antiviral fact sheet**

- Remdesivir fact sheet: 1 PATIENT INFORMATION VEKLURY® (VEK-lur-ee) (remdesivir) for injection VEKLURY® (VEK-lur-ee) (remdesivir) injection What is VE
- Patient was informed of risks and benefits of therapy, availability of alternatives and that the drug is FDA approved.
- Patients understand they have the option to accept or refuse treatments and, understanding the risks, benefits and alternatives, have agreed to accept treatment.

SARS-CoV-2 Remdesivir DOSING

Remdesivir (Veklury)

Age 12 yo or great and at least 40 kg:

☐ remdesivir 200 mg IV in NS 40mL on ☐ Day 1 followed by remdesivir 100mg IV in NS 60mL on ☐ Day 2 & ☐ Day 3

- Infuse over 30-120 minutes

Age 28 days to less than 12 years, weighing at least 3 kg to less than 40 kg:

☐ remdesivir 5 mg/kg IV on ☐ Day 1 followed by 2.5 mg/kg IV on ☐ Day 2 & ☐ Day 3

- Infuse over 30-120 minutes

☐ **If CKD is present or an eGFR of <30 is suspected, please obtain renal panel prior to infusion**

Post-Infusion:

- **Flush administration set with 0.9% sodium chloride to deliver residual volume.**
- **Leave IV in place for observation period; remove prior to discharge.**
- **Monitor patients for hypersensitivity reactions for a period of 60 minutes following infusion.**
- **Record vital signs immediately following infusion and prior to discharge.**
- **Provide patients with discharge instructions. Send record of treatment to prescriber at fax number as appropriate.**
- **If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medications and/or supportive therapy (see ADVERSE REACTIONS below)**

ADVERSE REACTIONS

MINOR REACTIONS (e.g. nausea, itching, joint pain, rash)	SEVERE REACTIONS (e.g. bronchospasm, loss of airway, fainting, severe flushing)
STOP infusion	**CALL A CODE OR RAPID RESPONSE**
diphenhydrAMINE 50 mg IV Push Once	**STOP** infusion
famotidine 20 mg IV Push Once	EPINEPHrine 0.3 mg/0.3 mL SubCutaneous Once
dexaMETHasone 10 mg IV Push Once	Oxygen PRN
Notify Physician	Notify Physician

Prescriber Signature_____ **Date/Time**_____