FAX or EMAIL PATIENT STICKER

SUBJECT: COVID-19 Monoclonal Antibody Infusion Order
TO: Comanche County Memorial Hospital Infusion Services
FAX: (580)585-5472
ADDRESS: 2712 W Gore Blvd Lawton, OK 73505
EMAIL: infusion@ccmhhealth.com
PHONE: (580)355-8699m Option 1, Ext 4756 for Scheduling Ext. 6194

FORMS MUST BE COMPLETE (NO BLANKS) AND SIGNED BY THE PROVIDER FOR THE PATIENT TO BE CONSIDERED FOR casirivimab/imdevimab or bamlanivimab/etesevimab

PLEASE PRINT

DATE:_____ **VACCINATION STATUS:**_____
PATIENT NAME:_____ **DOB:**_____
PHONE:_____ **HEIGHT (inches):**_____**INCHES** **WEIGHT:(kg)**_____**KG**
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

● Banner SARS-CoV-2 Specific Monoclonal Antibody Guidelines available in Banner COVID Toolkit.
● Casirivimab/imdevimab and bamlanivimab/etesevimab are investigational drugs and are not currently FDA approved for any indication.
● The FDA issued two separate Emergency Use Authorization (EUA) to authorize the emergency use of casirivimab/imdevimab or bamlanivimab/etesevimab respectively for the treatment of mild to moderate COVID-19 with positive results of direct SARS-CoV-2 viral testing who are at high risk for progressing to severe COVID-19 and/or hospitalization.

- Casirivimab and imdevimab EUA provider fact sheet available at Https://www.fda.gov/media/143892/download
- Bamlanivimab and etesevimab EUA provider fact sheet available at: https://www.fda.gov/media/145802/download

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SARS-CoV-2 Specific Monoclonal Antibody CRITERIA FOR USE

☐ Symptom Onset Date: _____Positive COVID-19 test date_____ OR exposure date_____

Patient must meet **ALL** criteria to be eligible for casirivimab/imdevimab or bamlanivimab/etesevimab consideration.

☐ at least 12 years of age and weighing at least 40 kg

☐ COVID-19 positive by PCR or Antigen testing

OR

☐ Post-Exposure Prophylaxis to COVID-19 for those at high risk for progression to severe COVID-19 AND who are not fully vaccinated -or- have an immunocompromising condition. If there is a supply issue, then COVID-19 positive patients will be infused prior to the patients for Post Exposure Prophylaxis patients.

☐ Meets all of the following requirements:

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

SARS-CoV-2 Specific Monoclonal Antibody CRITERIA FOR USE (continued)

☐ Does not have suspected or proven serious, active bacterial, fungal, viral, or other infection (excluding COVID-19)

☐ **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

☐ Neurodevelopment disorders or other conditions that confer medical complexity(e.g., genetic, or metabolic syndrome)

☐ **Patient or caregiver received a copy of the APPROPRIATE mAB INFUSION fact sheet**

- casirivimab/imdevimab factsheet https://www.fda.gov/media/143893/download, and
- bamlanivimab/etesevimab factsheet at https://www.fda.gov/media/145803/download
- Patient was informed of risks and benefits of therapy, availability of alternatives and that the drug is an unapproved drug authorized for use under the Emergency Use Authorization.
- Patients understand they have the option to accept or refuse treatments and, understanding the risks, benefits and alternatives, have agreed to accept treatment with casirivimab/imdevimab or bamlanivimab/etesevimab based on drug availability.

SARS-CoV-2 Specific Monoclonal Antibody DOSING

Pharmacy may dispense casirivimab/imdevimab or bamlanivimab/etesevimab based on availability for facility

☐ casirivimab 600 mg and imdevimab 600 mg ☐ bamlanivimab 700 mg and etesevimab 1400 mg

- added to 100 mL 0.9% NaCl IV Infusion Once, Infuse over 31 minutes, use 0.2/0.22 micron in-line filter

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MONITORING

1. Obtain vital signs prior to casirivimab/imdevimab or bamlanivimab/etesevimab administration
2. Monitor vital signs every 15 minutes during infusion and every 30 minutes thereafter
3. Clinically monitor patients during infusion and for at least 1 hour after infusion completes
4. 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

Provider Signature_____ **Date/Time**_____