INFUSION ORDERS: COVID Monoclonal Antibody: casirivimab and imdevimab (REGEN-COV)

Name:_____ DOB:_____

Date of symptom onset:_____Medication Allergies: _____

Height: _____ inches Weight:_____kg Patient Phone #:_____

Emergency use of casirivimab and imdevimab (REGEN-COV) is authorized for the treatment of mild to moderate COVID-19 disease in adults and pediatric patients (age 12 and older weighing at least 40kg) with positive direct SARS-Co V-s viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. Please mark the criteria that places this patient in the high risk category. Failure to indicate eligibility criteria may result in treatment delay or denial.

____ Age ≥ 65 years
____ Pregnancy
____ Chronic kidney disease
____ Diabetes
____ Sickle cell disease
____ Neurodevelopmental disorders
____ Immunosuppressive disease or immunosuppressive treatment
____ Cardiovascular disease (including congenital heart disease) or hypertension
____ Chronic lung disease (COPD, moderate to severe asthma, interstitial lung disease, CF, pulmonary hypertension)
____ Obesity (BMI > 25kg/m2, or if age 12-17, have BMI ≥ 85th percentile for age and gender based on CDC growth charts, https://www.cdc.gov/growthcarts/clinical charts.htm
____ Dependence on medical-related technology (tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)

This therapy is NOT authorized for use in patients who are hospitalized due to COVID-19, who require oxygen therapy due to COVID-19, or who require 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

COVID MONOCLONAL ANTIBODY TREATMENT:

_X_ Casirivimab 600 mg/imdevimab 600 mg (REGEN-COV) in 50 mL sodium chloride 0.9% Infused over 20 minutes x 1 dose. Monitor for infusion reactions during administration.
_X_ After infusion is complete, flush the tubing with sodium chloride 0.9% injection to ensure delivery of the entire dose.
_X_ Observe patients for at least 1 hour after infusion is complete for infusion-related reactions.
_X_ Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1)
_X_ Ondansetron ODT 4 mg sublingual x 1 if nauseous

My signature below indicates that I have discussed the risks and benefits of this therapy and a signed informed consent is attached.

Provider Sign:_____(Print):_____Date:_____Time:_____

Please fax a copy of the completed order and the signed consent form to 406-447-2719

PATIENT IDENTIFICATION:

St. Peter's Health
2475 Broadway • Helena, MT 59601 (406) 442-2480

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ORD.PHY

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