AltaMed
QUALITY CARE WITHOUT EXCEPTION™

MONOCLONAL ANTIBODY INFUSION ORDER FOR COVID-19 POSITIVE PATIENTS

INSTRUCTIONS: REQUIRED STEPS

* Print & fill out manually OR download & fill out electronically:

* Use Adobe Acrobat  and select 

** Instructions for changing default program for PDFs to Acrobat*

☐ PROVIDER: Place Epic order "Referral to Home Health > IV Infusion" + mark order as **Urgent**

☐ Under order comments enter "*MONOCLONAL ANTIBODY THERAPY*"

☐ Fill out the attached **Infusion Order Form**

** Team member may complete form based on documentation in Epic, but PROVIDER must sign*

☐ **Completed AND signed form** must be RETURNED to AltaMed Centralized Referral Team for urgent processing:

Provider or Clinic CGC's can return form via
Email: DL_Referral_Coordinators@altamed.org
or Fax: (323) 596-2166

☐ **Send message** to *Justin Maldonado* on WebEx Teams to confirm that ORDER is placed & form emailed/faxed

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MONOCLONAL ANTIBODY INFUSION ORDER FOR COVID-19 POSITIVE PATIENTS (Adult and Pediatric Patients)

☐ The patient or his/her guardian have provided their informed consent for the administration of **REGEN-COV (Casirivimab + Imdevimab)**

☐ I have notified the patient that this therapy is approved for emergency use by the FDA.

Home Infusion Provider Order Form for Casirivimab + Imdevimab
Patient Name: _____ DOB: _____
Patient Phone #: _____
Allergies: _____
Patient's Height (in) or (cm): _____ Patient's Weight (lb) or (kg):_____
Is Patient Pregnant? ☐ Yes ☐ No
Date of First COVID related Symptom Onset: _____
COVID Positive test Date: _____

DIAGNOSIS:
☒ Covid-19 Infection (U07.1)
☐ Other: _____

Administer Monoclonal Antibody Drug Therapy within 10 days of symptom onset.

***Patient Eligibility* Exclusion Criteria:** (Patients meeting any of the following criteria are NOT ELIGIBLE for either therapy)

a) who are hospitalized due to COVID-19
b) who require oxygen therapy due to COVID-19
c) 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

By signing this order, physician verifies that none of the above criteria apply.

Inclusion Criteria:

- Patient is 12 years of age or older weighting at least 40 kg (88.2lbs)

At least one of the following criteria must be met to qualify for therapy (*Select all that apply*):

☐ **Older age** (for example, age ≥65 years of age)

☐ Obesity or being overweight (for example, BMI >25 kg/m^2, or if **age 12-17**, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm

☐ Pregnancy
☐ Chronic kidney disease
☐ Diabetes
☐ Immunosuppressive disease or immunosuppressive treatment
☐ Cardiovascular disease (including congenital heart disease) or hypertension
☐ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
☐ Sickle cell disease
☐ Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID 19)

IV Infusion Orders

☒ Casirivimab 600 mg and Imdevimab 600 mg administered together as a single intravenous infusion via pump or gravity. Casirivimab and Imdevimab solutions must be diluted prior to administration.	*Procedure Code:* *M0243*

PRE-MEDICATION:

☐ Tylenol (Acetaminophen) 650 mg PO
☐ Benadryl 25 mg slow IVP
☐ Benadryl 25 mg PO
☐ Solu-medrol slow IVP 40 mg

IN CASE OF REACTION

☐ Solu-medrol 2 mg/kg IV (up to 125 mg)
☒ Anaphylaxis Kit, Use as directed (if not available at infusion location)

Other Infusion Orders:

☒ Provide all supplies and/or pump necessary to administer therapy. RN to start peripheral line when needed, access/maintain central IV access, administer (where app) RN to monitor 1 hour post infusion and treat ADR's and meds as ordered.
☒ Flush Intravenous access device per Infusion Protocol. Dispense Normal Saline and Heparin flushes as needed to maintain line # quantity sufficient for S.A.S.H.
☐ Other:

_____
_____

Clinical Services:
Pharmacy Services: Assessment of patient eligibility, administration method, education on medication side effects, interactions, adverse reactions, and infusion-related reactions.

Nursing Services: Skilled nursing to administer therapy, patient assessment, and monitoring.

Prescriber Name: **(Printed)** _____

Prescriber Name: **(Signature)** _____ Date: _____

Prescriber Address:

_____

Phone #: _____ Fax #: _____

Prescriber's License #: _____ Prescriber's NPI #_____

☒ *I certify that the above services are medically necessary and are authorized by me. This patient is under my care and is in need of the services listed.*