Mab Infusion Site

Patient Screening/Referral & Order Set Form

Today's Date: _____

Referring Physician Information

Physician Name: _____ NPI #: _____

Office Name: _____ Physician Phone: _____

Physician Email: _____ Physician Fax: _____

Patient Information

Patient Name: _____ DOB: _____ Age: _____

Cell Phone: _____ Email: _____

Transportation/Contact Name: _____ Cell Phone: _____

Emergency Contact Name: _____ Cell Phone: _____

Date of Onset of Illness (Mild to Moderate*) _____ = _____ Day of Illness (<10)

Check all symptoms that are present:

☐ Fever	☐ Malaise	☐ Nausea	☐ Loss of taste/smell
☐ Cough	☐ Headache	☐ Vomiting	☐ Shortness of breath
☐ Sore Throat	☐ Muscle Pain	☐ Diarrhea	☐ Dyspnea on exertion

Date of Testing for COVID: _____ Test Type: ☐ PCR ☐ Antigen

- Symptoms present less than 10 days: ☐ Yes ☐ No / STOP : Not Eligible
- SpO_2% greater than 93% on RA: ☐ Yes ☐ No / STOP : Not Eligible
- If previously on home O2, has no increased need: ☐ Yes ☐ No / STOP : Not Eligible ☐ N/A
- Stable for discharge home: ☐ Yes ☐ No / STOP : Not Eligible
- Documented positive COVID test performed: ☐ Yes ☐ No / STOP : Not Eligible

**NIH Definition:*

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have saturation of oxygen (SpO2) ≥94% on room air at sea level.

High Risk Patients Eligible for Care Who Meet One of the Following Criteria

Check below for each that meets the Monoclonal Antibody Infusion inclusion criteria:

- ☐ Older age (for example, age ≥65 years of age)
- ☐ Obesity or being overweight (for example, BMI >25 kg/m2)
- ☐ 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)
- ☐ High risk Ethnicity Groups (Latino or Black)

Appointment to infuse scheduled: _____ at _____ (before 10th day since symptom onset)

Provide Patient mAB Instruction Sheet, directions for infusion center and discharge

Email completed form to infusion@mynurx.com or fax to 956-435-0214

Monoclonal Antibody Infusion: Regeneron, Bamlanivimab + Etesevimab, or Sotrovimab Order Set

Eligibility Requirements

☐ Patient is not asymptomatic and has mild to moderate illness as noted by all of the following criteria:
- Is not hospitalized due to COVID-19, OR
- Does not require oxygen therapy due to COVID-19 and has a saturation of oxygen (SpO_2) ≥94% on room air at sea level, OR

☐ Patient is not:
- ☐ Day 10 or greater since symptom onset
- ☐ If pregnant, not cleared with OB/GYN Physician

Infusion Instructions for Available Monoclonal Antibody

IMPORTANT NOTE: Regeneron or Bamlanivimab + Etesevimab options must be checked to avoid inability to infuse your patient due to indeterminate monoclonal antibody supply.

☐ **If Regeneron is the available monoclonal antibody**, withdraw 5 mL of Casirivimab and 5 mL of Imdevimab from each respective vial using two separate syringes and dilute together in a 250 mL 0.9% NS (total volume 260mL) if not premixed. Infuse thru an in-line or add-on 0.20/0.22 micron polyethersulfone (PES) filter tubing over 60 minutes. Flush the infusion line to ensure delivery of the required dose at conclusion.

☐ **If Bamlanivimab + Etesevimab is the available monoclonal antibody,** infuse 700 mg of Bamlanivimab mixed as 1 vial 700 mg Bamlanivimab/20 mL and 1400 mg of Etesevimab as two vials of 700mg/20mL each inject all 60 mL into a prefilled infusion bag containing 0.9% Sodium Chloride in 250 mL 0.9% NS (total volume 310 mL) thru an in-line or add-on 0.20/0.22 micron polyethersulfone (PES) filter tubing over 60 minutes. Flush the infusion line to ensure delivery of the required dose at conclusion.

☐ **If Sotrovimab is the available non is the available monoclonal antibody available,** infuse 500 mg of Sotrovimab mixed as 1 vial 500 mg mg Sotrovimab/8 mL into a prefilled infusion bag containing 0.9% Sodium Chloride in 250 mL 0.9% NS (total volume 258 mL) thru an in-line or add-on 0.20/0.22 micron polyethersulfone (PES) filter tubing over 60 minutes. Flush the infusion line to ensure delivery of the required

☐ Monitor patients' vitals every 15 minutes during infusion for any adverse response (hypotension SBP<90, tachycardia (HR >100) or fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, dizziness.

☐ Stop infusion for any adverse response

☐ Notify MD any adverse response

☐ Call 911 any severe adverse response (Hypotension, bronchospasm, angioedema, severe bronchospasm)

1 Hour Post Infusion Completion

☐ Monitor patients' vitals every 30 minutes after infusion for any adverse response (hypotension SBP<90, tachycardia (HR >100) or fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, dizziness.

☐ Notify MD any adverse response

☐ Call 911 any severe adverse response (Hypotension, angioedema, anaphylaxis, severe bronchospasm)

☐ Remove IV and discontinue infusion if no adverse response at end of infusion.

As Needed Orders

Serious Adverse Events include: Angioedema, Anaphylaxis, Hypotension, or any Issue requiring EMS Transport by 911

☐ Nausea	If patient develops nausea, administer Zofran 4 mg IV x 1. May repeat in 1 hour if not improved
☐ Headache	If patient develops headache, administer 650 mg of Acetaminophen if not allergic
☐ Hives Itching Bronchospasm	• Administer Benadryl 12.5 mg IV. May repeat in 30 minutes if not improved. • Administer Solumedrol 1 mg/kg IV • Discontinue infusion • Apply monitor, Call 911 if severe
☐ Angioedema	• Administer Benadryl 12.5 mg IV. May repeat in 30 minutes if not improved. • Administer Solumedrol 1 mg/kg IV • Discontinue infusion • Apply monitor, Call 911
☐ Hypotension (SBP <90)	If patient develops hypotension, stop product and administer 1000 mL NS, discontinue infusion. • Apply monitor, call 911.
☐ Anaphylaxis	• Anaphylaxis must involve at least 2 body systems (Hypotension AND Hives as an example) • Epinephrine 1:1000: 0.01 mg/kg IM; max dose 0.3 mg (0.3 mL) IM or EpiPen. May repeat every 5 min up to 3 doses. • Discontinue infusion • Apply monitor, call 911 • Administer Benadryl 12.5 mg IV. May repeat in 15 minutes if not improved and EMS not arrived. • Administer Solumedrol 1 mg/kg IV

ADDENDUM to Monoclonal Antibody Infusion Care

- ☐ The following may be substituted when the IV form is not available:
  - ☐ Prednisone 20 mg tab 2 po once for Solumedrol 1 mg/kg IV or Dexamethasone 4 mg IV
  - ☐ Zofran 4 mg tab 1 po for Zofran 4 mg IV
  - ☐ Benadryl 25 mg 1 tab po for Benadryl 12.5 mg IV
- ☐ The following IV to IV may be substituted when the same drug is not available
  - ☐ Dexamethasone 4 mg IV for Solumedrol 1 mg/kg IV
- ☐ Generics may be substituted for name brand for any rescue medication listed (example, ondansetron for Zofran)
- ☐ Give patient the monoclonal antibody information which they were assigned for treatment
- ☐ Give patient the COVID-19 Care Guide for home care

Physician Name: _____ **Date:** _____

Physician Signature: _____