Logan Regional Medical Center Outpatient Order Form

Monoclonal Antibody Therapy for COVID-19 Treatment

Provider complete form and **fax to the pharmacy 304-831-1278** along with copy of insurance card/face sheet and **positive COVID Test**

***Patient will be contacted with appointment time ***

PATIENT INFORMATION

First Name: _____M.I. _____ Last Name: _____

D.O.B. _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____

Home ph: _____ Mobile ph: _____ Work/other:_____

Allergies: _____

MEDICATION ORDER:

- ✓ **COVID-19 Monoclonal Antibody per hospital protocol**
- ✓ Vital signs prior to start of infusion, during infusion and for one hour after infusion.
- ✓ In the event of allergic reaction:
    - Diphenhydramine 50 mg IV x 1 prn allergic reaction.
    - Famotidine 20 mg IV x 1 prn allergic reaction.
    - Solu-Medrol 80 mg IV X 1 prn allergic reaction.
    - Epinephrine 0.3 mg IM x 1 prn severe anaphylactic reaction
- ✓ Monitor patient for at least 1 hour after infusion is complete for signs of hypersensitivity including anaphylaxis and infusion-related reactions.

CRITERIA FOR USE (must be completed for approval):

1. Positive COVID-19 test result within 10 days. Positive test date: ____ / ____ / ____
2. Symptom onset within last 10 days. Symptom Onset date: ____ / ____ / ____
3. High risk criteria:

☐ **Age ≥ 65**
Priority given to those with any of the following risk factors (Circle):
Unvaccinated for COVID-19, Immunosuppressive disease/treatment, Active Cancer, BMI ≥ 25, Chronic kidney disease, Diabetes mellitus, pregnancy (recommend consult with OB/Ped regarding risk/benefit), cardiovascular disease, hypertension, Chronic lung disease, Sickle cell disease, Neurodevelopmental disorders, Having a medical-related technology dependence (i.e., trach, etc.)

☐ **Age 18-64 with any of the following (circle):** Unvaccinated for COVID-19, Immunosuppressive disease/treatment, Active Cancer, BMI ≥ 25, Chronic kidney disease, Diabetes mellitus, pregnancy (recommend consult with OB/Ped regarding risk/benefit), cardiovascular disease, hypertension, Chronic lung disease, Sickle cell disease, Neurodevelopmental disorders, Having a medical-related technology dependence (i.e., trach, etc.)

☐ **Age 12-17 at least 40 kg with any of the following (circle):** Unvaccinated for COVID-19, Immunosuppressive disease/treatment, Active Cancer, BMI ≥ 85th percentile for age/gender, Chronic kidney disease, Diabetes mellitus, pregnancy (recommend consult with OB/Ped regarding risk/benefit), cardiovascular disease, hypertension, Chronic lung disease,

Sickle cell disease, Neurodevelopmental disorders, Having a medical-related technology dependence (i.e., trach, etc.)

4. Patient is **ineligible** to receive treatment if any of the following apply:
   - ☐ Hospitalized due to COVID-19
   - ☐ Requiring oxygen due to COVID-19
   - ☐ Increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

5. Special Considerations:
   - Pregnancy – Recommend consult with OB/Ped regarding risk/benefit
   - B-Cell Immunodeficiencies (theoretical risk for immune escape and emergence of resistance to therapeutics)

As a healthcare provider, you must communicate to your patient or caregiver, information consistent with the "Fact Sheet for Patients, Parents and Caregivers" prior to scheduling an appointment for administration of either agent. A copy of the Fact Sheet will be given to the patient or caregiver when she or he arrives for infusion visit. Ordering healthcare providers must document in the patient's medical record that the patient/caregiver has been:

a. Given the "Fact Sheet for Patients, Parents and Caregivers"

b. Informed of alternatives to receiving authorized monoclonal antibody therapy

c. Informed that monoclonal antibody therapy is an unapproved drug that is authorized for use under an Emergency Use Authorization.

If a serious and unexpected adverse event occurs and appears to be associated with the use of this medication, the prescribing health care provider and/or the provider's designee shall complete and submit a MedWatch form to FDA using one of the following methods WITHIN 7 DAYS:

a. Complete and submit the report online: https://www.fda.gov/safety/medical-product-safety-information/medwatch-forms-fda-safety-reporting
b. Use a postage-paid Form FDA 3500 (available at http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf) and return by mail (MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787), or by fax (1-800-FDA-0178),
c. Call 1-800-FDA-1088 to request a reporting form

PHYSICIAN INFORMATION

Requesting Physician/Provider:_____ NPI #_____

Phone: _____ Fax: _____ Contact Person:_____

Physician/Provider Signature_____Date_____

Call 304-831-1343 with any questions