State of Texas Monoclonal Prophylaxis

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: _____

Home Address: _____ City, State: _____

Emergency Contact Name: _____ Cell Phone: _____

COVID-19 Fully Vaccinated (2 weeks past final dose) ☐ Yes ☐ Not Fully ☐ None

SECTION A: PROPHYLAXIS DATA NEEDED (COMPLETE SECTION A, B, C. All Three Conditions Must Be Met: Exposure + Prophylaxis Eligibility + High Risk)

Date of *Exposure (Must be Within Last 14 Days):

*Within 6 feet of COVID-positive individual for a cumulative total of 15 minutes or more over a 24-hour period.

SECTION B: Prophylaxis Eligibility Criteria

☐ Not Fully Vaccinated and have been exposed (CDC Defined Exposure Criteria*) to an individual with COVID-19 and **meets at least one Section C Criteria.**

☐ Not Fully Vaccinated, Resides in Institutional Setting where COVID-19 outbreak is identified, have high risk of exposure to an individual infected to with COVID-19 and **meets at least one Section C Criteria**.

☐ Fully Vaccinated but immunocompromised and have been exposed (CDC Defined Exposure Criteria*) to an individual with COVID-19.

☐ Fully Vaccinated, Resides in Institutional Setting where COVID-19 outbreak is identified, but immunocompromised and have high risk of exposure to an individual infected to with COVID-19.

SECTION C: Identify at Least One High Risk Eligibility Feature(s) Qualifying Adult Patient or Pediatric Patient (≥40 kg and is 12-17 years) for mAB Prophylaxis

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

☐ Obesity or being overweight (for example, BMI >25 kg/m2) or if 12 to 17 years of age, have BMI ≥85th percentile for their age and gender based on CDC growth charts,

☐ 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

☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation, not related to COVID-19)

☐ Other medical condition(s) or factor(s) placing patient at risk for progression to severe illness

I authorize the listed patient to undergo EUA monoclonal antibody therapy for mild to moderate illness using the order set as listed above without modification. I have identified the High-risk Eligibility Criteria (OR Prophylactic Eligibility Criteria that qualifies the patient for mAB therapy.

Physician Name: (Printed) _____ **Date:** _____

Physician Signature: _____

Monoclonal Antibody Infusion: Regeneron Order Set

SPECIAL Eligibility Considerations

☒ If pregnant or breast feeding, cleared with OB/GYN Physician.

Subcutaneous Injection or Infusion Instructions for Regeneron

IMPORTANT NOTE: All orders are pre-checked and allow the team to complete all aspects of related care.

☒ Administer Regeneron Subcutaneously per EUA Protocol unless there is a contraindication to SQ placement. Inject medication as 2.5mL if co-formulated in 4 separate quadrants avoiding any damaged or abnormal skin areas. Proceed to 1 hour Post Infusion/Injection observation after completion of injections

☒ If patient declines subcutaneous route or has a contraindication, infuse Regeneron IV. 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 co-formulated as 10mL. 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. (Other NS Diluent volumes can be used and are 150mL,100mL, and 50mL with administration minimum times as 31 min, 21 min, and 20 min, respectively).

☒ If given by infusion, 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.

☒ If given by infusion, stop infusion for any adverse response

☒ Notify Infusion Team MD any adverse response

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

1 Hour Post Infusion/Injection Completion

☒ Monitor patients' vitals every 30 minutes after infusion or subcutaneous injections 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 if placed for infusion if no adverse response. If given subcutaneously inspect SC injections sites. Discharge patient to home.

As Needed Orders

☒ Treat Nausea; Headache; Hives/Itching/Bronchospasm, Angioedema; Hypotension; Anaphylaxis per RIC Standing Orders

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

Email completed form to **InfusionReferral@bcfs.net** or fax to **210-208-5295**

For additional information, please call the **Infusion Hotline** @ **1-800-742-5990**

OFFICE USE ONLY

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

DATE **TIME**

Provide Patient mAB Instruction Sheet, directions for infusion

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