State of Texas Monoclonal Antibody Infusion

Patient Screening/Referral & Order Set Form

Today's Date: _____

Referring Physician/Medical Provider Information

Physician/MP Name: _____ NPI #: _____

Office Name: _____ Physician/MP Phone: _____

Physician/MP Email: _____ Physician/MP Fax: _____

Patient Information

Patient Name: _____ DOB: _____ Age: _____

Cell Phone: _____ Email: _____

Home Address: _____ City, State: _____

Emergency Contact Name: _____ Cell Phone: _____

COVID-19 Vaccine Fully Immunized ☐ Yes ☐ No

"Date of Illness Onset OR Date of COVID + Test (whichever is earliest):" _____

- Symptoms present less than 10 days: ☐ Yes ☐ No / STOP : Not Eligible
- SpO_2% greater than 93% on RA: ☐ Yes ☐ No / STOP : Not Eligible
- If on Oxygen chronically, is on same rate: ☐ Yes ☐ No / STOP : Not Eligible ☐ N/A
- Stable for home management/care: ☐ Yes ☐ No / STOP : Not Eligible
- Documented positive COVID test performed: ☐ Yes ☐ No / STOP : Not Eligible

Identify High Risk Eligibility Feature(s) Qualifying Patient for mAB Therapy

Check at least one of the following medical conditions or other factors that may place adults and pediatric patients (age 12-17 years and weighing at least 40 kg) at higher risk for progression to severe COVID-19:

- ☐ 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, COPD, 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)
- ☐ 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 below without modification. I have identified the High-risk eligibility criteria above that qualifies the patient for mAB therapy.

Physician/Medical Provider Name: (Printed) _____ **Date:** _____

Physician/Medical Provider Signature: _____

Monoclonal Antibody Infusion: Multi-mAB Order Set

Special Eligibility Requirements

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

Infusion Instructions for Available Monoclonal Antibody

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

☒ If **Regeneron** is the available monoclonal antibody, withdraw 5 mL (2.5mL x2 if half dose vials) of Casirivimab and 5 mL (2.5mL x2 if half dose vials) of Imdevimab from each respective vial (s) using separate syringes and dilute together in a 250 mL 0.9% NS (total volume 260 mL) if not co-formulated as 10 mL. Gently invert infusion bag by hand approximately 10 times to mix. Do not shake. Infuse through 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, 100 mL, and 50 mL with administration minimum times as 31 min and 30 min respectively.

- ☒ If **Bamlanivimab and Etesevimab** is the available monoclonal antibody, withdraw 1 vial (700 mg) of Bamlanivimab (700 mg/20 mL=1 vial) and withdraw 2 vials (1400 mg) Etesevimab (700 mg/20 mL=1 vial), using separate syringes and dilute together in a 250 mL, ,100 mL, or 50 mL 0.9% NS (total volume 320 mL, 160 mL, 110 mL). Gently invert the bag by hand approximately 10 times to mix. Do not shake. Infuse through an in-line or add-on 0.20/0.22-micron polyethersulfone (PES) filter tubing over a minimum of 60 min , 31 min and 30 min respectively. Flush the infusion line to ensure delivery of the required dose at conclusion. If using 250 mL NS diluent in patients <50 kg, but >40 kg must run over 70 minutes or more
- ☒ If **Sotrovimab** is the available monoclonal antibody, withdraw 8 mL from 1 vial (1 vial=500 mg/8 mL) of Sotrovimab and dilute in a 100 mL or 50 mL 0.9% NS or 5% Dextrose Injection total volume 108 mL or 58 mL). Gently rock the bag by hand approximately 3 to 5 times to mix. Do not invert the infusion bag. Do not shake. Infuse through an in-line or add-on 0.20/0.22-micron polyethersulfone (PES) filter tubing over a minimum of 30 minutes. Once the infusion is complete flush the line with 0.9% NS or 5% Dextrose Injection to ensure delivery of the entire dose.
- ☒ Monitor patients' vitals every 15 minutes if infused over 31-60 minutes, every 10 minutes if infused at 30 minutes or less 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 Infusion Team MD of any adverse response
- ☒ Call 911 for any severe adverse response (Hypotension, bronchospasm, angioedema, severe bronchospasm)
- ☒ **REGENERON ONLY:** Administer **Regeneron** subcutaneously per EUA Protocol if unable to start IV. Inject medication as 2.5mL if co-formulated in 4 separate quadrants avoiding any damaged or abnormal skin areas. Inject as 2.5 mL of Casirivimab in 2 quadrants and Imdevimab 2.5 mL in 2 additional but separate quadrants if packaged separately.

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 Infusion Team MD any adverse response
- ☒ Call 911 any severe adverse response (Hypotension, angioedema, anaphylaxis, severe bronchospasm)
- ☒ Remove IV and discontinue if no adverse response at end of observation.

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.
- Email completed form to **InfusionReferral@bcfs.net** or fax to **210-208-5295**
- For additional information, please call the State of Texas Infusion Hotline @ 1-800-742-5990