MERCYONE℠

Patient Label

COVID-19 Monoclonal Antibody Treatment

Patient Name: _____ DOB: _____

Patient's Phone Number: _____

Patient Eligibility (Check all that apply) - Must have a positive SARS-CoV-2 viral test within last 10 days (No other positive tests in previous 90 days), and symptoms present for no more than 10 days to be eligible

❑ **Positive SARS-CoV-2 viral test date:** _____

❑ **Symptom onset date:** _____

Adults: Age 18 years or greater AND at least 40 kg, Plus any of the following:

- ❑ Obesity (BMI greater than or equal to 35)
- ❑ Age greater than or equal to 65 years
- ❑ Chronic kidney disease
- ❑ Diabetes
- ❑ Immunosuppressive disease
- ❑ Immunosuppressive treatment
- ❑ Age greater than or equal to 55 AND have one of the following:
  - ❑ Cardiovascular disease
  - ❑ Hypertension
  - ❑ Chronic obstructive pulmonary disease or other chronic respiratory disease

Pediatrics: 12-17 years of age AND at least 40 kg, plus any of the following:

- ❑ BMI greater than or equal to the 85th percentile for their age and gender based on CDC growth charts
- ❑ Sickle cell disease
- ❑ Congenital or acquired heart disease
- ❑ Neurodevelopmental disorder
- ❑ Medical-related technological dependence (chronic, not related to COVID diagnosis)
  - ❑ Tracheostomy
  - ❑ Gastrostomy
  - ❑ Other _____
- ❑ Asthma, reactive airway, or other chronic respiratory disease that requires daily medication for control

Nursing

- ☑ Insert peripheral IV line
- ☑ After infusion complete, monitor patient for one (1) hour for signs/symptoms of adverse effects and allergic reaction

Medications

- ☑ ONE product will be chosen by pharmacy based on availability in the following order:
  1. Casirivimab 1200 mg AND imdevimab 1200 mg IV Piggyback 1-Time
     Comments: Infuse with an in-line filter 0.2 microns. After infusion complete, flush the infusion line to ensure delivery of the full dose. OR
  2. Bamlanivimab 700 mg IV Piggyback 1-Time
     Comments: Infuse with an in-line filter 0.2 microns. After infusion complete, flush the infusion line to ensure delivery of the full dose.
- ☑ Sodium Chloride 0.9% flush, 3 mL, IV Push, See Comment, PRN to flush IV line
  Comments: Flush IV line after bamlanivimab infusion
- ☑ Diphenhydramine 25 mg IV push 1-Time as needed for minor infusion reactions such as itching
- ☑ Diphenhydramine 50 mg IV push 1-Time as needed for hypersensitivity reaction such as rash or anaphylaxis
- ☑ Epinephrine (1 mg/mL) 0.5 mg IM 1-Time as needed for serious allergic reaction

Provider Name: _____ Date: _____

I attest that the patient has been informed of the risks and benefits of bamlanivimab treatment:

_____ _____

Provider Signature Date/Time

Fax completed form to MercyOne Infusion Center: 515-643-8926

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Patient Chart Copy
Orders