MOUNT NITTANY HEALTH

Adult (age 18 and older) Monoclonal Antibody Healthcare Provider Order Form

This form will act as the Healthcare Providers order and MUST be FULLY completed.
Providers – please do the following:

1. **FAX the completed form to both 814.278.4625 and 814.231.3738** AND
2. **CALL 814.234.6106, option 5** to schedule the patient appointment.

If you have questions, you may call 814.234.6193.

1. Monoclonal Antibody Therapy will be provided to up to 14 patients in ASU; Tuesday through Friday (excluding holidays) based on drug availability.
2. Patients will be contacted for Pre-Registration after the appointment is made by the provider.
3. Patients will report to the Mount Nittany Medical Center- Main Entrance and go to the Registration Desk 15 minutes prior to their scheduled appointment time.
4. Patients must wear face mask over their mouth and nose during the entire visit, which will be approx. 2-3 hours.
5. No visitors may accompany patients. Please contact ASU at 814.234.6193 to discuss any special needs.
6. Patients may eat breakfast and take their medications as usual.
7. If unable to attend the appointment, the patient should call Central Scheduling at 814.234.6106.
8. Patients must have a provider order, no self-referrals will be accepted.

Patient Information

Last Name: _____ Gender: ___M ___F ___U

First Name: _____ Phone Number: _____

DOB: _____ Age: _____ Weight: _____ BMI: _____

COVID Illness Information			
Date of COVID testing			_____
Date of COVID symptom onset *Will not be eligible if infusion date is greater than 10 days *Day 1 starts with first day of symptoms			_____
Symptoms: *Must be symptomatic to qualify			
○ Shortness of breath ○ Nasal congestion ○ Sore throat	○ Cough ○ N/V/D ○ Loss of taste/smell		○ Fever/Chills ○ Fatigue ○ Other _____
Vaccination Status			
○ Fully vaccinated plus booster	○ Fully vaccinated		
○ Partially vaccinated	○ Not vaccinated		
Exclusion Criteria		***Yes***	***No***
Allergic to casirivimab, imdevimab, sotrovimab, L-histidine, L-histidine monohydrochloride, L-methionine, polysorbate 80 or sucrose?		☐	☐
Weighs less than 88 pounds?		☐	☐
Hospitalized for this instance of COVID 19?		☐	☐
If on home oxygen therapy, has there been an increase in oxygen liter flow related to this COVID 19 illness?		☐	☐

Patient Name: _____ DOB: _____

***Patient must meet at least one high risk criteria item to be eligible for monoclonal antibody therapy.**

High Risk Criteria	***Yes***	***No***
Age greater than 64 years	☐	☐
Obesity with BMI greater than 25 kg/m^2	☐	☐
Pregnancy	☐	☐
Chronic kidney disease	☐	☐
Diabetes	☐	☐
Immunosuppressive disease or treatment	☐	☐
Cardiovascular disease or hypertension	☐	☐
Chronic lung diseases (ex:COPD, mod-severe asthma, CF)	☐	☐
Sickle cell disease	☐	☐
Neurodevelopmental disorders (ex: Cerebral palsy)	☐	☐
Medical-related technological dependence (ex: trach)	☐	☐

Additional Information*:* _____

_____

Medication Orders:

COVID-19 Monoclonal Antibody

(Pharmacy to determine option based on allocated supply and/or community resistance patterns)

- Sotrovimab 500mg IV in NSS 100mL over 30 minutes. Administered with 0.2micron filter and flushed with NSS 30mL AFTER completion of infusion.
- Casirivimab/Imdevimab (Regen-Cov) 600mg/600mg IV in NSS 100mL over 20 minutes. Administered with 0.2micron filter and flushed with NSS 30mL AFTER completion of infusion.

Infusion Related Reaction(s)

- Monitor for infusion reaction(s) during and for at least 1 hr AFTER infusion complete.
- Contact provider w/ ANY signs & symptoms of infusion-related reactions which may include: fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, urticaria/rash, pruritus, myalgia, dizziness.

For Infusion Related Reactions *(automatically ordered—strike out if NOT wanted)*

- ✓ Acetaminophen 650mg PO ONCE prn pain/headache. Do not give if dose received within previous 4 hours. *Notify ordering provider if administered*.
- ✓ Ondansetron 4mg IV ONCE prn N/V. *Notify ordering provider if administered*.
- ✓ Diphenhydramine 25mg IV q 15 mins (max 2 doses) prn urticaria/swelling. *Notify ordering provider if administered*.
- ✓ Methylprednisolone 125mg IV ONCE prn stridor/new wheezing/SOB. *Notify ordering provider if administered*.
- ✓ Epinephrine 0.3mg IM ONCE prn anaphylaxis. *Notify ordering provider if administered*.

Healthcare Provider (Signature): _____ Date: _____ Time: _____

Healthcare Provider (Print Name): _____

Provider /Office contact number _____ *Provider # that can be easily reached.