# Village Treatment Center

## ORDER FORM for COVID-19 Antibody Infusion or Subcutaneous Injection

Step 1: Please complete form and fax to 501-922-0921 along with a copy of positive COVID-19 result.
Step 2: Once the completed paperwork has been received, a pharmacy representative will contact the patient to coordinate services as soon as possible.

**Patient Name (Last, First, MI)**: _____ **Date of Birth**: _____

**Sex: _____ Weight**: _____ kg **Height**: _____ in **Best contact numbe**r: _____

**Drug Allergies**:_____

**Diagnosis (Please select)**:

- ☐ Mild to Moderate COVID-19 Date of Symptom Onset:_____
- ☐ Post-Exposure Prophylaxis

| **Indication:** Emergency Use Authorization (non-FDA approved) for treatment of mild to moderate coronavirus disease 2019 (COVID-19) in adult and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. | |
|---|---|
| The patient must meet one or more of the criteria below to be considered high-risk. Please check the to indicate the criteria this patient meets: | Limitations of Use. REGEN-COV is NOT authorized for use as treatment in patients: |
| ☐ BMI ≥ 31<br>☐ Chronic Kidney Disease<br>☐ Diabetes<br>☐ ≥ 65 years of age<br>☐ Immunosuppressive disease or currently receiving immunosuppressive treatment<br>☐ ≥ 55 years of age AND have cardiovascular disease, hypertension, or COPD/chronic respiratory disease<br>☐ 12-17 years of age AND either BMI ≥ 85th percentile per CDC growth chart, sickle cell disease, heart disease, neurodevelopmental disorders, a medical-related technology dependence (i.e. tracheostomy), or reactive airway disease that requires daily medication | • Who are hospitalized due to COVID-19, OR<br>• Who require oxygen therapy due to COVID-19, OR<br>• Who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity |

**Medication Ordered**: REGEN-COV (casirivimab and imdevimab)

**Dose Ordered (Indication Specific)**:

- ☐ 600 mg casirivimab and 600 mg imdevimab (initial dose for treatment or post-exposure prophylaxis)
- ☐ 300 mg casirivimab and 300 mg imdevimab (subsequent dosing for continued prophylaxis)

I attest that the patient meets the above criteria and have provided the patient/caregiver with the "Fact Sheet for Patients, Parents, and Caregivers" for casirivimab-imdevimab, informed of alternatives to receiving casirivimab-imdevimab, informed that this medication is an unapproved drug that is authorized for use under the Emergency Use Authorization, and documented all of this in the patient's medical record.

_____ _____ _____

**Ordering Provider Signature** **Date** **Time**

Patient Name: _____ Date of Birth: _____

**Emergency Management Orders:**

- ☐ **Diphenhydramine (Benadryl) 25mg PO x 1 for mild allergic reaction; 50 mg po x1 for moderate reaction**
- ☐ **Diphenhydramine (Benadryl) 25mg IM x 1 for moderate allergic reaction if unable to take PO**
- ☐ **Epinephrine (Adrenalin)** 0.3 mg IM x 1 prn severe anaphylactic reaction and call 911

**Management of Reaction/Anaphylaxis:**

**Mild Allergic Reaction** (flushing, dizziness, headache, sweating, palpitations, nausea):

- Administer diphenhydramine (Benadryl) - 25mg PO
- Assess vital signs at 5-10 intervals
- If symptoms subside, resume administration of medication if not completed
- If symptoms persist, notify the prescriber before resuming administration

**Moderate Allergic Reaction** (chest tightness, shortness of breath, hypotension/hypertension (> 20mmHg change in systolic BP), increased temperature, palpitations, urticaria, flushing)

- Slow or stop medication administration
- Administer diphenhydramine (Benadryl) - 50mg PO or 25mg IM if unable to take PO
- Assess vital signs at 5-10 minute intervals
- If symptoms subside, resume administration of medication if not completed
- If symptoms persist, notify prescriber before resuming administration
- If symptoms worsen, follow severe reaction steps

**Severe Allergic Reaction/Anaphylaxis** (hypotension/hypertension (>40mmHg change in systolic BP), increased temperature with rigors, chest tightness, shortness of breath with wheezing, stridor)

- Stop medication administration
- Call 911
- Position patient on the back or position of comfort if respiratory distress or vomiting occur
- Assess the patient's circulation, airway, breathing, mental status, and skin
- Inject epinephrine 0.3mg in the anterolateral aspect of the thigh. Repeat in 5-10 minutes if needed
- Administer CPR if needed at any time
- Monitor vital signs at 5-10 minute intervals until arrival of EMS

**Monitoring**

- Document name of medical professional administering the medication
- Document Vital Signs: Temperature, HR, BP, RR, Pulse Ox taken before medication initiation; immediately after medication administration; and 1 hour post medication administration
- Medical professional to monitor patient 1 hour post medication administration
- Document time of medication administration
- Schedule patient follow-up with provider between days 4 and 7 to assess COVID-19 symptoms and treatment tolerance
- Note any adverse reactions - if no healthcare professional is on site, please call the pharmacy at 501-922-0909 for appropriate reporting to MedWatch (will need detail on the date/type of reaction)

| | | |
|---|---|---|
| ☐ Fever<br>☐ Headache<br>☐ Angioedema<br>☐ Throat irritation | ☐ Chills<br>☐ Bronchospasm<br>☐ Rash, including urticaria<br>☐ Pruritus | ☐ Nausea<br>☐ Hypotension<br>☐ Myalgia<br>☐ Dizziness |

Patient Name: _____ Date of Birth: _____

## ORDERING PHYSICIAN OR NURSE PRACTITIONER INFORMATION (REQUIRED)

Physician or Nurse Practitioner Full Name: _____

_____
NPI

_____
Address

_____ _____ _____
City State ZIP

Office Contact: _____

Phone: _____ Fax: _____

_____ _____
MD/NP Signature (Required) Date

If Verbal Order: Received by: _____ Read back and confirmed on: _____

## COMPLETE THE FOLLOWING SECTION DURING MEDICATION ADMINISTRATION

**Route of Administration**:

- ☐ Subcutaneous Injection
- ☐ Intravenous Infusion (Rate of Infusion: _____ ; Volume Infused: _____)

Person Administering Medication Full Name: _____

Medication Administration Started: _____ _____
Date Time

Medication Administration Stopped: _____ _____
Date Time

| Vital Sign | Prior to Medication Administration | Immediately After Medication Administration | 1 Hour Post Medication Administration |
|---|---|---|---|
| **Temp** | | | |
| **HR** | | | |
| **BP** | | | |
| **RR** | | | |
| **PulseOx** | | | |

Patient Follow-Up Phone Appointment Date: _____

Patient Name: _____ Date of Birth: _____