**Monoclonal Antibody**

**CASIRIVIMAB & IMDEVIMAB Injection**

**For Accordia Health Monoclonal Antibody Clinic**

# FAX COVER SHEET

| | | | |
|---|---|---|---|
| **To:** | Accordia Health Monoclonal Antibody Clinic | **From:** | |
| **Fax:** | 251-281-2437 | **Sender Fax:** | |
| **Phone:** | 251-305-4550 | **Sender Phone:** | |
| **Subject:** | Patient Information for appointment | **Date:** | |

**No. Pages:**

**Comments:**

The following documents are REQUIRED to send:

- ☐ Physician Orders – signed, MUST be complete and include: patient ALLERGIES; date of COVID Positive test; and date of symptoms
- ☐ Patient Consent – signed by patient and provider
- ☐ Patient demographics sheet with updated phone number, last 4 of SS# and insurance information.

Accordia Health will call the patient within 24 hours to schedule appointment –

Patients on Friday should be prepared to receive injections on Monday if appropriate.

Please be sure all paperwork above is included in the fax for timely appointment scheduling.

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## PHYSICIAN'S ORDERS

Patient Name: _____ DOB: _____

Weight: _____ Height: _____ ALLERGIES/Reactions: _____

| Physician's Orders | |
|---|---|
| Status | Outpatient |
| Indication | Mild to Moderate COVID-19 infection in patients 12 yr. & older and weigh at least 40 kg with a high risk of progression to severe COVID-19 and/or hospitalization.<br>Date of SARS-CoV-2 positive test result: ____/____/____ Date of symptom onset: ____/____/____<br>**High Risk Criteria:**<br>☐ Age ≥ 65 yr ☐ Obesity or being overweight (adults BMI > 25; age 12-17 ≥ 85th percentile)<br>☐ Pregnancy ☐ Immunosuppressive disease or immunosuppressive treatment<br>☐ Chronic Kidney Disease ☐ Sickle cell disease<br>☐ Diabetes<br>☐ Chronic lung disease (COPD, asthma, interstitial lung disease, cystic fibrosis, and pulmonary hypertension)<br>☐ Cardiovascular disease (including congenital heart disease) or hypertension<br>☐ Neurodevelopmental disorders (cerebral palsy) or other conditions that confer medical complexity<br>☐ Having medical-related technological dependence (tracheostomy, gastrostomy, or PPV (non-COVID))<br>☐ Other medical conditions or factors that place patients at high risk for progressing to severe COVID-19 (example: race or ethnicity) |
| Consent and Patient Information | Review with patient the Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) of Casirivimab & Imdevimab for Coronavirus Disease 2019.<br>Verify patient consent for Casirivimab & Imdevimab obtained and in chart prior to administration. |
| Clinical Care Orders | Vital signs at baseline. |
| | Inspect vial for discoloration or particulate matter. **Do not expose to direct heat. Do not shake the vial.**<br>Using 4 syringes, withdraw 2.5mL of Casirivimab & Imdevimab into each syringe for subcutaneous injection<br>Administer immediately (if not possible store at room temp for no more than 4 hours)<br>If medication refrigerated, allow to equilibrate to room temp for about 20 min prior to administration.<br>Administer the subcutaneous injections consecutively, each at a different injection site (thigh, back of upper arm, or abdomen [except for 2 inches around the navel]) The waistline should be avoided.<br>It is recommended using different quadrants of the abdomen or upper thighs or back of the upper arms to space apart<br>DO NOT inject into skin that is tender, damaged, bruised, or scarred |
| | Vital signs every 15 minutes after injection. Clinically monitor patients for at least one hour |
| | Common reactions: fever, chills, nausea, headache, bronchospasm, difficulty breathing, arrhythmia, chest pain or discomfort, weakness, altered mental status, hypotension, hypertension, angioedema, throat irritation, rash including urticarial, pruritus, myalgia, vasovagal reactions (pre-syncope, syncope), dizziness fatigue and diaphoresis. |
| Treatment and Medications for an injection reaction | ☐ Oxygen via nasal cannula or non-rebreather mask PRN difficulty breathing or decreased O2 saturation<br>☐ Bag-Valve Mask breathing with Oxygen PRN for apnea or slow, shallow breathing<br>☐ Diphenhydramine 25 mg IM once PRN for an injection reaction<br>☐ Dexamethasone 4 mg IM once PRN for an injection reaction<br>☐ Acetaminophen 650 mg PO once PRN for an injection reaction<br>☐ Epinephrine 0.3 mg INTRAMUSCULAR (EpiPen 0.3 mg auto-injector) once PRN for an injection reaction<br>Call Physician if patient develops anaphylaxis symptoms.<br>Call EMS/ambulance for transport to hospital |
| Other | Report any adverse events/reactions to AltaPointe Health Systems Compliance Department and via RL-6. |
| Patient Instructions | Continue to self-isolate and use infection control procedures (social distance, wear mask, wash hands) per CDC<br>Notify Healthcare provider for worsening symptoms. |

Provider Signature: _____ Date: _____

Printed Provider Name: _____ Phone: _____

Collaborating Physician Signature (if applicable) _____

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**PATIENT CONSENT**

I have received and reviewed the Patient Fact Sheet for Casirivimab/Imdevimab.

I have been informed of alternative treatments.

I understand that this drug is not approved by the FDA, and that it has been authorized for emergency use only.

I consent to receive Casirivimab/Imdevimab treatment under Emergency Use Authorization (EUA) for COVID-19.

PATIENT Name: _____

Signature: _____

Date: _____/_____/_____ Time: _____

**HEALTHCARE PROFESSIONAL ATTESTATION**

I have explained the treatment to the patient/authorized representative and have answered all questions about this treatment to the best of my ability.

Printed Name/Credentials: _____

Signature: _____

Date: _____/_____/_____ Time: _____