

Casirivimab and Imdevimab Emergency Use Authorization Order

Patient Name: _____ Date of Birth: _____ Phone#: _____

Address: _____ Height (in.): _____ Weight (Kg): _____

Ordering Provider: _____ Phone: _____

Address: _____

Patient has a confirmed positive test and diagnosis of Covid-19 (UO7.1) and meets EUA criteria: (mark all that apply)

Must be ordered within 5 days of symptom onset and positive Covid-19 test result.

Date of symptom onset: _____ Date of positive test result: _____

Age 18 - 54 years AND at least 2 of the following: BMI \geq 35 Chronic Kidney Disease Stage 3 or higher Diabetes requiring medication for control

Age \geq 55 years AND at least 1 of the following: BMI \geq 35 Chronic Kidney Disease Stage 3 or higher Diabetes requiring medication for control COPD or other respiratory disease Cardiovascular disease or hypertension requiring medication for control

Age 12 to 17 years AND \geq 40 kg AND 1 of the following: BMI \geq 85th percentile based on CDC growth charts Sickle cell disease Neurodevelopmental disorders such as cerebral palsy A medical-related technological dependence such as a tracheostomy, gastrostomy, or positive pressure ventilation unrelated to Covid-19 Asthma or reactive airway or chronic respiratory disease requiring daily medication Congenital or acquired heart disease

Age \geq 12 years AND \geq 40 kg AND Immunosuppressive disease or currently receiving immunosuppressive treatment

Orders:

1) Casirivimab 1200 mg and Imdevimab 1200 mg in 0.9% NaCl 230 mL for total infusion volume of 250 mL to be administered via IV infusion at a rate of 250 mL/hr over 60 minutes. (0.2/0.22 micron filter required)

2) 0.9% NaCl 1000 ml to be infused at 20 ml/hr to maintain IV access.

3) Saline Flush 25 ml IV. Flush line after infusion of Casirivimab and Imdevimab is complete.

4) Clinically monitor patient during the infusion and for 60 minutes post infusion.

5) Emergency medications PRN:

diphenhydrAMINE (Benadryl) injection 25 mg IV once for anaphylaxis and/or infusion reactions.

EPINEPHrine PF (Adrenalin) injection 0.3 mg IM once for anaphylaxis and/or infusion reactions.

methylPREDNISolone Na Succ. (SOLU-Medrol) injection 125 mg IV once for anaphylaxis and/or infusion reactions.

_____ (Provider Initials) By initialing here, the provider is acknowledging that the patient, legal guardian, and/or caregiver:

- have been met AND that the patient and/or caregiver have been provided a copy of the FDA approved Fact Sheet for Patients, Parents and Caregivers for Casirivimab and Imdevimab treatment.
- have been informed that Casirivimab and Imdevimab is an unapproved drug that is authorized for use under this Emergency Use Authorization (EUA).
- have been informed of alternatives to receiving Casirivimab and Imdevimab.

Provider Signature: _____ Date: _____ Time: _____

Prior to completing/submitting this order the provider has contacted United Regional Health Care System at phone number (940) 764-6080 and confirmed availability of product.

After confirming product availability, this order must be faxed to (940) 764-4060. The patient will be contacted by a URHCS staff member to schedule the infusion.

****This order WILL NOT be processed if the entire form is not complete and the patient does not meet criteria****