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 10 days of symptom onset and positive Covid-19 test result.
Date of symptom onset:_____ **Date of positive test result:**_____

□ Age ≥ 12 years AND at least 40 kg with one of the following: □ BMI ≥ 35 □ Chronic Kidney Disease Stage 3 or higher □ Diabetes requiring medication for control □ Immunosuppressive disease or currently receiving immunosuppressive treatment

□ Age ≥ 55 years AND at least 1 of the following: □ COPD or other respiratory disease requiring medication for control
□ Cardiovascular disease or hypertension requiring medication for control

□ Age 12 to 17 years AND ≥ 40 kg AND 1 of the following: □ BMI ≥ 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 ≥ 65 years

Orders:

1) Casirivimab 600 mg and Imdevimab 600 mg in 0.9% NaCl 50 mL for total infusion volume of 60 mL to be administered via IV infusion at a rate of 180 mL/hr over 20 minutes. (0.2/0.22 micron filter required)

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

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

4) 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.
0.9% NaCl 1000 ml to be infused at 20 ml/hr to maintain IV access.

_____ (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:**_____

Hospital may substitute Bamlanivimab if Casirivimab and Imdevimab are unavailable and the pharmacist deems it is appropriate to do so.

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****