Monoclonal Antibody Bamlanivimab
Order Form for Adults Patients ≥ 12 Years Old

PATIENT NAME:	DOB:
ALLERGIES:	POSITIVE COVID-19 TEST ON:
FDA PATIENT FACT SHEET PROVIDED ON: *** Per FDA EUA, bamlanivimab patient education and patient fact sheet must be provided to the patient prior to administration.**	

PATIENT SCREENING

- ☐ Age (≥ 12 y.o.): _____
- ☐ Weight (≥ 40 kg): ____
- ☐ Mild to moderate COVID-19; high risk for progressing to severe COVID-19 and/or hospitalization

Patient meets at least one of the following criteria:

- ☐ Is ≥ 65 years of age
- ☐ Has a body mass index (BMI) ≥ 25
- ☐ Pregnancy
- ☐ Has chronic kidney disease
- ☐ Has diabetes
- ☐ Has immunosuppressive disease
- ☐ Is currently receiving immunosuppressive treatment
- ☐ Cardiovascular disease or hypertension
- ☐ Chronic lung diseases
- ☐ Sickle cell disease
- ☐ Neurodevelopmental disorders or other conditions that confer medical complexity
- ☐ Having a medical-related technological dependence not related to COVID-19
- ☐ Other medical conditions or factors that place the patient at high risk for progressing to severe COVID-19
  Describe: _____

Monoclonal Antibodies are NOT AUTHORIZED for use in patients: Who are hospitalized due to COVID-19, OR Who require oxygen therapy due to COVID-19, OR Who require an increase in baseline oxygen flowrate due to COVID-19 for those on chronic oxygen therapy due to an underlying non-COVID-19 related co-morbidity.

- ☐ Patient does not meet any of the above contraindications

Prescribed Medication

☐ **700 mg bamlanivimab and 1,400 mg etesevimab**

Per EUA, must be diluted together as a single intravenous infusion. Add 20 mL of bamlanivimab (1 vial) and 40 mL of etesevimab (2 vials) for a total of 60 mL to a prefilled infusion bag and administer together as a single intravenous infusion as instructed in the Health Care Providers Fact Sheet.

To be documented at time of infusion:

Bamlanivimab LOT Number: _____ **Expiration Date:** _____

Etesevimab LOT Number: _____ **Expiration Date** _____

☐ **600 mg casirivimab and 600 mg imdevimab**

Per EUA, must be diluted together as a single intravenous infusion. Add 5 mL of casirivimab (1 vial of 11.1 mL or 2 vials of 2.5 mL) and 5 mL of imdevimab (1 vial of 11.1 mL or 2 vials of 2.5 mL) for a total of 10 mL to a prefilled infusion bag and administer together as a single intravenous infusion as instructed in the Health Care Providers Fact Sheet. If IV access is not obtainable, may administer subcutaneously per the Health Care Providers Fact Sheet.

To be documented at time of infusion:

Casirivimab LOT Number: _____ **Expiration Date:** _____

Imdevimab LOT Number: _____ **Expiration Date** _____

Administering Provider **Signature** **Date**

Developed 12/10/2020
Revised 06/09/2021

POST-INFUSION

- ☐ Flush administration set with 0.9% sodium chloride to deliver residual volume.
- ☐ Leave IV in place for observation period; remove prior to discharge.
- ☐ Monitor patient for hypersensitivity reaction for a period of 60 minutes following infusion.
- ☐ Send record of treatment and post infusion summary (page 5) to prescriber at fax number below

MANAGEMENT OF HYPERSENSITIVITY

Patients must be clinically monitored during infusion and observed for at least one hour after infusion is complete. Vital signs must be measure before infusion and ≤ q 30 minutes, and when indicated until conclusion of observation period.

Management of Minor Infusion-Related Symptoms	
Nausea/Vomiting	☐ Ondansetron (Zofran): 4 mg ODT (oral dissolving tablet) or 4 mg IV
Headache/Fever	☐ Acetaminophen: 650-1,000 mg PO
*** Minor infusion related symptoms such as nausea, headache, fever, and dizziness can often improve with slowing infusion rate. For minor symptoms early in the infusion, decrease infusion rate by 25-50%.	

Management of Severe (non-anaphylactic) Infusion-Related Symptoms

*** Immediately stop infusion, obtain vital signs, initiate supplemental oxygen, as indicated. Activate the emergency medical system (EMS; e.g., call 911 if applicable) and notify the patient's physician/clinician. This should be done by a second person, while the primary healthcare professional assesses the airway, breathing, circulation and level of consciousness of the patient.

Management of Anaphylactic Symptoms	
Anaphylaxis	☐ **Epinephrine 0.3 mg IM; if signs of hypotension and/or respiratory distress with wheezes or stridor are present, repeat dose every 5 to 15 minutes for up to two doses and diphenhydramine as described below.** ☐ Diphenhydramine 50 mg IM or IV (administer alone for moderate symptoms)
*** Immediately stop infusion, obtain vital signs, initiate supplemental oxygen as indicated, administer medications as above, limit epinephrine to shock or severe respiratory distress. Call EMS and continue supportive care, while monitoring patient closely until arrival. Notify the patient's physician/clinician as soon as able.	

ADDITIONAL ORDERS

ORDERING PRESCRIBER

Prescriber Name: _____ Prescriber Signature: _____

Direct Contact Number: (___) ___ – _____ Fax Number: (___) ___ – _____

Order date: _____

REPORTING REQUIREMENTS

In accordance with the Michigan Public Health Code (MCL 331.531), the following survey must be completed for each patient treated with monoclonal antibody (MAB) therapy supplied through the State of Michigan: https://forms.office.com/Pages/ResponsePage.aspx?id=sgF4Zzdipk67RItjfx6ergRINfmr3E1Njq-ZF3K4vsBUMjRaVE43VjM1MFJRTllCVzBMMk9HWVVBTiQlQCN0PWcu.

Developed 12/10/2020
Revised 06/09/2021

POST INFUSION SUMMARY
☐ No infusion related problems **Additional Comments:**

Patients, Parents and Caregivers EUA Resources:

☐ **Fact Sheet for Patients, Parents and Caregivers Emergency Use Authorization (EUA) of Bamlanivimab and Etesevimab for Coronavirus Disease 2019 (COVID-19): https://www.fda.gov/media/145803/download**

☐ **Fact Sheet For Patients, Parents and Caregivers Emergency Use Authorization (EUA) of Casirivimab and Imdevimab for Coronavirus Disease 2019 (COIV-19): https://www.fda.gov/media/143893/download**

Patient Consent: by signing this I attest to have read, or had explained to me, the patient fact sheet for the monoclonal antibody that I am receiving and have been provided an opportunity to ask questions, which have been answered to my satisfaction. I understand the potential risks and benefits associated with monoclonal antibody therapy and agree to receive the infusion of this medication.

Form Completed by/Relationship to Patient **Signature** **Date**