



Prescriber agrees:

- I understand this drug is not authorized for use in hospitalized coronavirus disease 2019 (COVID-19) patients, patients requiring oxygen therapy due to COVID-19, patients who require an increase in baseline oxygen flow rate due to COVID-19 and the patient or his/her guardian have provided their informed consent for the administration of Casirivimab/Imdevimab.
- I understand Casirivimab/Imdevimab should only be used for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older weighing at least 40 kg, and who are at high risk for progressing to severe COVID-19 and/or hospitalization, and when the known and potential benefits to patients outweigh the known and potential risks of such product.

Patient Information

Patient Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Facility	Room/Bed	Height	Weight

Clinical Information

Date of positive COVID-19 test result	Date of symptom onset and disease manifestation
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Adult Patient meets at least one of the following criteria (Check all that apply)

- Has a body mass index (BMI) ≥ 35
- Has chronic kidney disease
- Has diabetes
- Has immunosuppressive disease
- Is currently receiving immunosuppressive treatment
- Is ≥ 65 years of age

OR

- Patient is ≥ 55 years of age **AND** has Cardiovascular disease **OR** Hypertension **OR**
- Chronic obstructive pulmonary disease/other chronic respiratory disease

Orders

- Establish vascular access, if needed (peripheral IV)
- Casirivimab 1200mg/Imdevimab 1200 mg IV in 250 mL 0.9% Sodium Chloride administered over at least 60 minutes
- Follow infusion with 0.9 % Sodium Chloride 25 mL to infuse at same rate as infusion to clear administration set of drug post infusion
- 0.9% Sodium Chloride 10 mL flush PRN
- Acute infusion reaction orders: **PHARMACY TO PROVIDE IN ANAPHYLAXIS KIT**

Check	Drug or Treatment	Severity	Over 30 kg	Route	Note
<input type="checkbox"/>	Epinephrine 1 mg/mL amp (1:1000)	Moderate to Severe	<input type="checkbox"/> 0.3 mg	<input type="checkbox"/> SQ <input type="checkbox"/> IM	<input type="checkbox"/> Repeat in 3-5 mins PRN
<input type="checkbox"/>	Diphenhydramine Oral	Mild	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	PO	
<input type="checkbox"/>	Diphenhydramine 50mg/mL vial	Moderate to Severe	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	Slow IV or IM	<input type="checkbox"/> Repeat in 3-5 mins PRN MAX dose = 50 mg
<input type="checkbox"/>	Methylprednisolone Sodium Succinate 125mg/2mL	Moderate to Severe	125 mg	<input type="checkbox"/> IM <input type="checkbox"/> IV	x 1 dose
<input type="checkbox"/>	Albuterol inhaler	Moderate to Severe	90 mcg/act	INHALER	1-2 puffs PRN

Facility Nurse to call/fax above information to physician/LIP. Either have physician/LIP sign below, or obtain as a telephone order.

Nurse	Print Name	Date
Physician/prescriber	Print Name	Date

Pharmacy Name: _____ **FAX COMPLETED FORM TO (_____)** _____ - _____

PLEASE NOTE: PHARMACY MAY REQUIRE ADDITIONAL INFORMATION BEFORE ORDERS CAN BE PROCESSED.