ContinuumRx Specialty Infusion Services™

Fax: 877-438-9380

Home Infusion Provider Bamlanivimab Order Form

Patient Name: ______________________________________ DOB: ________________________

Facility Name (if applicable): _____________________________ Phone: _______________________

Address: ____ City: _______________ State: ______

Physician: ________________________________ Allergies: ____________________________

Date of First Symptom Onset: ___________________ COVID Positive Result Date: _____________

☐ **Please send a copy of H&P and demographic information along with signed order**

Patient Eligibility

Exclusion Criteria (Patients meeting any of the following criteria are NOT ELIGIBLE for bamlanivimab therapy)

a. who are hospitalized due to COVID-19
b. who require oxygen therapy due to COVID-19
c. who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

By signing this order, physician verifies that none of the above criteria apply.

Inclusion Criteria: (at least one of the following criteria must be met to qualify for bamlanivimab therapy)

Check all that apply (replace letters with check boxes):

☐Patient is 12 years of age or older weighting at least 40 kg

Patient Weight: __________ kg Date: _____________

Patients must have at least one of the following (select all that apply):

- ☐ Body Mass Index greater to or equal to 35
- ☐ Chronic Kidney Disease
- ☐ Diabetes
- ☐ Immunosuppressive Disease (i.e. CVID)
- ☐ Currently receiving immunosuppressive treatment
- ☐ ≥ 65 years of age
- ☐ ≥ 55 years of age, AND have at least one of the following: Cardiovascular disease, Hypertension, COPD or other respiratory disease
- ☐ Ages 12-17 AND have at least one of the following:
  - ☐ BMI ≥ 85th percentile for the age & gender based on the CDC growth charts (https://www.cdc.gov/growthcharts/clinical_charts.htm)
  - ☐ Sickle Cell Disease
  - ☐ Congenital or Acquired heart disease
  - ☐ Neurodevelopmental disorders
  - ☐ Medical-related technological dependence (i.e. tracheostomy, gastrostomy, ventilator (not related to COVID-19)
  - ☐ Asthma, Reactive airway, or other chronic respiratory disease requiring daily medication

Home Infusion Orders:

☐ Bamlanivimab ***700mg/200 ml*** 0.9% Sodium Chloride to be infused via gravity or infusion pump over 60 minutes x 1 dose (Must use a 0.2 or 0.22 micron filter for administration)

☐ 50ml 0.9% Sodium Chloride

Once infusion is complete, flush the infusion line with 50ml 0.9% Sodium Chloride to ensure delivery of required dose.

☐ Anaphylaxis Kit if not available at infusion location

☐ Diphenhydramine 50mg/ml – Administer Diphenhydramine 25-50mg IV or IM x 1 PRN infusion reaction

☐ Epinephrine 1mg/ml – Administer Epinephrine 0.3mg SQ or IM x 1 PRN anaphylactic drug reaction

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Additional Infusion Drug Orders

1. ____

2. ____

Vascular Access Device (VAD) Orders:

Flush Protocol: ____

0.9% NS: ____ml Instructions: __SASH____

Heparin __u/ml; ___ml Instructions: __SASH____

Peripheral Vascular Access Device: Skilled nursing to assess and insert peripheral access device for administration of bamalanivimab.

Other:
____

______

Clinical Services:
Pharmacy Services: Assessment of patient eligibility, administration method, education on medication side effects, interactions, adverse reactions, and infusion-related reactions.
Nursing Services: Skilled nursing to administer bamlanivimab, patient assessment, and monitoring.

Physician Signature: ____

Date: _____________________