Monoclonal Antibody Infusion Scheduling Instructions

Please note, at this time, we are unable to offer antibody infusions to patients exposed to COVID without a positive test. Effective 11/24/2021, we have instituted a **risk stratification method** by which the highest risk patients are given scheduling priority. We may not be able to meet the requests for patients of medium and low risk though we will try to accommodate them.

If you have a COVID positive patient who is within **10 days** of symptom onset and meets clinical criteria, please complete the following steps to schedule them for the Monoclonal Antibody Infusion. **Please note that if you do not follow these steps to schedule, it may result in missed or delayed treatment.**

From Oaklawn Medical Group Office or express care site:

- Complete form A-45, attached. Please make sure to fill out all required fields, including physician signature and date of symptom onset. A new form is required to be filled out for each patient.
- Fax the completed form to 269-789-4924. The patient will not be scheduled until the form is received.
- Send an urgent patient case in Athena to surgery scheduling using the surgeryorders bucket. Put "Monoclonal Antibody Infusion" in the subject line.
- Tell your patient that you will call them with the appointment time and date.
- Await a response from scheduler to patient care (in provider staff bucket). **No need to call Surgery Scheduling.**

From a site outside Oaklawn Medical Group:

- Complete form A-45, attached. Please make sure to fill out all required fields, including physician signature and date of symptom onset. A new form is required to be filled out for each patient.
- Fax the completed form to 269-789-4924. The patient will not be scheduled until the form is received.
- After faxing the completed form, please call 269-789-3915 Option 1 for Surgery Scheduling. Please hold for your call to be answered. **Please do not leave a voicemail during business hours.**
- If after hours, weekends, or holidays, please wait to call on the next business day and hold until your call can be answered.

Please be sure to tell patients that they will be contracted with their appointment date and time based on available staff and medication and not all patients will be accommodated. Patients should plan to arrive to Registration 30 minutes before their appointment and plan to be here for 2-3 hours. Visitors are not allowed to accompany patients unless there is an extenuating circumstance, this will need to be noted at the time of scheduling. There may be up to 4 patients in a room receiving infusions at the same time. Patients are required to remain masked throughout the duration of their infusion.

orderfo

Monoclonal Antibody Order Form for Patients ≥ 12 Years Old

Oaklawn

PATIENT NAME/PHONE NUMBER:	DOB:	DATE OF SYMPTOM ONSET:
ALLERGIES:	DATE OF POSITIVE TEST:	
FDA PATIENT FACT SHEET* PROVIDED ON:		

* Per FDA EUA, patient education and patient fact sheet must be provided to the patient prior to administration.

Patient Screening by Risk Stratification

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

HIGH RISK
- ☐ Is ≥ 65 years of age
- ☐ Moderately-severely immunocompromised
- ☐ Active cancer
- ☐ Body mass index (BMI) ≥ 35
- ☐ Pregnant or within 6 weeks of delivery
- ☐ Chronic lung disease (including moderate-severe asthma)
- ☐ Diabetes
- ☐ Chronic kidney disease ≥ stage 3
- ☐ Medical-related technological dependence
- ☐ Sickle cell disease

MEDIUM RISK
- ☐ Chronic cardiovascular conditions
- ☐ Cerebrovascular disease/chronic neurologic condition
- ☐ Severe mood or substance use disorder
- ☐ Chronic liver disease
- ☐ Current smoker
- ☐ Pediatric BMI over 95th percentile
- ☐ Adult who did not start/complete primary COVID vaccination series

LOW RISK
- ☐ Former smoker
- ☐ BMI 25-34.9
- ☐ Pediatric BMI 85-95th percentile

Monoclonal antibody treatments are NOT AUTHORIZED for use in patients with: 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 listed contraindications

Prescribed Drug

**Oaklawn Pharmacy reserves the right to interchange an ordered monoclonal antibody infusion product per available stock. Please check the box if you wish to receive a call prior to substitution. ☐

☐ **600 mg casirivimab and 600 mg imdevimab**
Per EUA, must be diluted together as a single intravenous infusion. Add 5 mL of casirivimab (2 vials of 2.5 mL) and 5 mL of imdevimab (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:
https://www.fda.gov/media/143892/download.

To be documented at time of infusion:
Casirivimab **LOT Number:** _____ **Expiration Date:** _____
Imdevimab **LOT Number:** _____ **Expiration Date:** _____

☐ **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:
https://www.fda.gov/media/145801/download.

To be documented at time of infusion:
Bamlanivimab **LOT Number:** _____ **Expiration Date:** _____
Etesevimab **LOT Number:** _____ **Expiration Date:** _____

☐ **500 mg Sotrovimab**
Per EUA, **NOT FOR PROPHYLAXIS**. Add 8 mL of Sotrovimab (500mg) and add to prefilled infusion bag and administer as a single intravenous infusion over 30 minutes as instruced in the Health Care Providers Face Sheet:
https://www.fda.gov/media/149534/download.
To be documented at time of infusion: **LOT Number:**_____ **Expiration Date:**_____

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

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.** ☐ 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.

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 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**

Please fax completed form to **269-789-4924** and call Scheduling at **269-789-3915** option 1 to schedule the patient.

APPOINTMENT DATE/TIME: