



Monoclonal Antibody Infusion Scheduling Instructions

Effective 2/7/2022, we have updated the priority criteria for highest risk patients to category 1A and 1B only. Per guidance from MDHHS, Sotrovimab will be the only infusion offered due to the effectiveness with the omicron variant.

If you have a patient who is within **10 days** of symptom onset or exposure that meets Tier 1A 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.



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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.		

PLEASE CHECK EVERY BOX THAT APPLIES FOR YOUR PATIENT

Vaccination Status:

None	First Dose	Second Dose	Third Dose
	Type: _____	Type: _____	Type: _____
	Date: _____	Date: _____	Date: _____

Tier 1A (Sotrovimab)

Patient of any age (per applicable EUA) with moderate to severe immunocompromise regardless of vaccination status

- Active treatment for solid tumor and hematologic malignancies
 - Receipt of solid-organ transplant and taking immunosuppressive therapy
 - Receipt of CAR-T-cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppression therapy)
 - Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
 - Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm³, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)
- Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

Age ≥75 y.o. and not up to date on COVID vaccines¹

Tier 1B (Sotrovimab)

Pregnant and not up to date on COVID vaccines¹

¹Those not up to date include those who are not vaccinated, have not completed their initial series, and those not boosted when eligible as per CDC

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 flow-rate 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 contraindication.

Prescribed DRUG

- 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 instructed 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: _____

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

Administering Provider

Signature

Date

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 \leq 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=sgF4Zzdipk67Rltjfx6ergRINfmr3E1Niq-ZF3K4vsBUMjRaVE43VjM1MEJRTICVzBMMk9HWVVBTiQIQCN0PWcu>

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 Sotrovimab for Coronavirus Disease 2019 (COIV-19): <https://www.fda.gov/media/149534/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: _____