Monoclonal Antibody Infusion Scheduling Instructions

If you have a patient who is within **7 days** of symptom onset or exposure that 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.

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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.		

PLEASE CHECK EVERY BOX THAT APPLIES FOR YOUR PATIENT

Vaccination Status:

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

****Scheduling priority will be based on the tier for which the patient meets qualifications****

Tier 1A

☐ Patient of any age (per applicable EUA) with moderate to severe immunocompromise[3] regardless of vaccination status
☐ Age ≥75 y.o. and not up to date on COVID vaccines[1]

Tier 1B

☐ Age 65-74 y.o., not up to date on COVID vaccines[1], and with MI priority risk factors[2]
☐ Pregnant and not up to date on COVID vaccines[1]

Tier 2

☐ Age 65-74 y.o. and not up to date on COVID vaccines[1]
☐ Age <65 y.o., not up to date on COVID vaccines[1] with MI priority risk factors[2]

[1]Those 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

[2]MI priority risk factors include:

☐ Obesity (BMI ≥35)
☐ Chronic respiratory disease (e.g., COPD, moderate or severe asthma requiring daily inhaled corticosteroid, bronchiectasis, CF, ILD)
☐ Pregnancy (mAb therapy only) (Note: In pregnancy, molnupiravir should not be used and Paxlovid used with caution when other mAb is unavailable)
☐ Chronic Kidney Disease (stage III, IV, or end stage CKD-GFR) (special considerations with Paxlovid)
☐ Cardiovascular disease (e.g., HTN, valvular disease, CVA, PAD, CHF)
☐ Diabetes

[3]Moderate to severe immunocompromise

☐ Been receiving active cancer treatment for tumors or cancers of the blood
☐ Received an organ transplant and are taking medicine to suppress the immune system
☐ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
☐ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
☐ Advance or untreated HIV infection
☐ Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

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

**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. ☐

☐ **175 mg Bebtelovimab**

Per EUA, remove bebtelovimab vial from refrigerator and allow to equilibrate to room temperature for approximately 20 minutes. Withdraw 175 mg (2 mL) of bebtelovimab (1 vial) into disposable syringe. Attach syringe to syringe extension set and prime. Administer as a single intravenous injection over at least 30 seconds as instructed in the Health Care Providers Fact Sheet: **https://pi.lilly.com/eua/bebtelovimab-eua-factsheet-hcp.pdf**.

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

Management of Hypersensitivity

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

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 moderatesymptoms)
*** 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: _____