Mobile Infusion Task Force (MITF)

Patient Screening/Referral & Order Set Form

Today's Date: _____

Referring Physician Information

Physician Name: _____ NPI #: _____

Office Name: _____ Physician Phone: _____

Physician Email: _____ Physician Fax: _____

Patient Information

Patient Name: _____ DOB: _____ Age: _____

Cell Phone: _____ Email: _____

Infusion Address: _____ City, State: _____

Emergency Contact Name: _____ Cell Phone: _____

Date of Onset of Illness (Days of Illness ≤10 days) _____

Check all symptoms present:

☐ Fever	☐ Malaise	☐ Nausea	☐ Loss of taste/smell
☐ Cough	☐ Headache	☐ Vomiting	☐ Shortness of breath
☐ Sore Throat	☐ Muscle Pain	☐ Diarrhea	☐ Dyspnea on exertion

- Symptoms present less than 10 days: ○ Yes ○ No / STOP: Not Eligible
- SpO_2% greater than 93% on RA: ○ Yes ○ No / STOP: Not Eligible
- If on Oxygen chronically, is on same rate: ○ Yes ○ No / STOP: Not Eligible ○ N/A
- Stable for home management/care: ○ Yes ○ No / STOP: Not Eligible
- Documented positive COVID test performed: ○ Yes* ○ No / STOP: Not Eligible

* Date of COVID-19 Testing: _____ Test Type: ☐PCR ☐Antigen ☐No Test

NIH Definition:

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have saturation of oxygen (SpO2) ≥94% on room air at sea level.

Identify High Risk Eligibility Feature(s) Qualifying Patient for mAB Therapy

Check at least one high risk category your patient has meeting Monoclonal Antibody Infusion use criteria **and** is 18 years of age and older:

- ☐ Older age (for example, age ≥65 years of age)
- ☐ Obesity or being overweight (for example, BMI >25 kg/m2)
- ☐ Pregnancy
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease or immunosuppressive treatment
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- ☐ Sickle cell disease
- ☐ Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- ☐ Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation, not related to COVID-19)
- ☐ High risk Ethnicity Groups (Latino or Black)

Monoclonal Antibody Infusion: Regeneron Order Set

Eligibility Requirements

☒ Patient is symptomatic (not asymptomatic) and has mild to moderate illness as noted by all of the following criteria:
- Is not hospitalized due to COVID-19
- Does not require oxygen therapy due to COVID-19 and has a saturation of oxygen (SpO_2) ≥94% on room air at sea level, OR

☒ Patient is:
- ☒ Day 10 or less since symptom onset or testing positive.
- ☒ If pregnant, cleared with OB/GYN Physician.

Infusion Instructions for Available Monoclonal Antibody

IMPORTANT NOTE: All orders are pre-checked and allow the infusion team to complete all aspects of infusion related care.

☒ **Regeneron is the available monoclonal antibody**, withdraw 5 mL of Casirivimab and 5 mL of Imdevimab from each respective vial using two separate syringes and dilute together in a 250 mL 0.9% NS (total volume 260mL) if not co-formulated as 10mL. Infuse thru an in-line or add-on 0.20/0.22 micron polyethersulfone (PES) filter tubing over 60 minutes. Flush the infusion line to ensure delivery of the required dose at conclusion.

☒ Monitor patients' vitals every 15 minutes during infusion for any adverse response (hypotension SBP<90, tachycardia (HR >100) or fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, dizziness.

☒ Stop infusion for any adverse response

☒ Notify Infusion Team MD any adverse response

☒ Call 911 any severe adverse response (Hypotension, bronchospasm, angioedema, severe bronchospasm)

1 Hour Post Infusion Completion

☒ Monitor patients' vitals every 30 minutes after infusion for any adverse response (hypotension SBP<90, tachycardia (HR >100) or fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, dizziness.

☒ Notify MD any adverse response

☒ Call 911 any severe adverse response (Hypotension, angioedema, anaphylaxis, severe bronchospasm)

☒ Remove IV and discontinue infusion if no adverse response at end of infusion.

As Needed Orders

Serious Adverse Events include: Angioedema, Anaphylaxis, Hypotension, or any Issue requiring EMS Transport by 911

☒ Nausea	If patient develops nausea, administer Zofran 4 mg IV x 1. May repeat in 1 hour if not improved
☒ Headache	If patient develops headache, administer 650 mg of Acetaminophen if not allergic
☒ Hives Itching Bronchospasm	• Administer Benadryl 12.5 mg IV. May repeat in 30 minutes if not improved. • Administer Solumedrol 1 mg/kg IV • Discontinue infusion • Apply monitor, Call 911 if severe
☒ Angioedema	• Administer Benadryl 12.5 mg IV. May repeat in 30 minutes if not improved. • Administer Solumedrol 1 mg/kg IV • Discontinue infusion • Apply monitor, Call 911
☒ Hypotension (SBP <90)	If patient develops hypotension, stop product and administer 1000 mL NS, discontinue infusion. • Apply monitor, call 911.
☒ Anaphylaxis	• Anaphylaxis must involve at least 2 body systems (Hypotension AND Hives as an example) • Epinephrine 1:1000: 0.01 mg/kg IM; max dose 0.3 mg (0.3 mL) IM or EpiPen. May repeat every 5 min up to 3 doses. • Discontinue infusion • Apply monitor, call 911 • Administer Benadryl 12.5 mg IV. May repeat in 15 minutes if not improved and EMS not arrived. • Administer Solumedrol 1 mg/kg IV

ADDENDUM to Monoclonal Antibody Infusion Care

- ☒ The following may be substituted when the IV form is not available:
  - ☒ Prednisone 20 mg tab 2 po once for Solumedrol 1 mg/kg IV or Dexamethasone 4 mg IV
  - ☒ Zofran 4 mg tab 1 po for Zofran 4 mg IV
  - ☒ Benadryl 25 mg 1 tab po for Benadryl 12.5 mg IV
- ☒ The following IV to IV may be substituted when the same drug is not available
  - ☒ Dexamethasone 4 mg IV for Solumedrol 1 mg/kg IV
- ☒ Generics may be substituted for name brand for any rescue medication listed (example, ondansetron for Zofran)
- ☒ Give patient the monoclonal antibody information which they were assigned for treatment
- ☒ Give patient the COVID-19 Care Guide for home care

I authorize the listed patient to undergo EUA monoclonal antibody therapy for mild to moderate illness using the order set as listed above without modification. I have identified the High-risk Eligibility criteria above that qualifies the patient for mAB therapy.

Physician Name: (Printed) _____ **Date:** _____

Physician Signature: _____

Email completed form to **InfusionReferral@bcfs.net** or fax to **210-208-5295**

For additional information: **Infusion Hotline 1-800-742-5990**

OFFICE USE ONLY

Appointment to infuse scheduled: _____ at _____ (on or before 10th day since symptom onset)

Provide Patient mAB Instruction Sheet, directions for infusion

Clear All Form Fields