AMBER SPECIALTY PHARMACY

P: (877) 794.9833
F: (855) 370.0086

Bamlanivimab/Etesevimab Infusion Order Form

Patient Name:_____ DOB:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Patient SS #: _____ Allergies:_____ Pt. Weight:_____lbs/kg
Physician:_____ NPI: _____
Insurance Name:_____ Patient ID:_____
Please Circle: Date of First Symptom or Exposure Onset:_____ COVID Positive Date:_____

Please send face sheet or copy of insurance cards. If Medicare patient, please include SSN

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: _____

COVID Positive Patients: Therapy must begin within 10 days of Symptom onset regardless of COVID positive test date High Risk Patients must have at least one of the following (select all that apply):

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/Etesevimab 1400mg 160 ml 0.9% Sodium Chloride to be infused via gravity or infusion pump over 30 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.

Physician Signature: _____ Printed:_____ Date:_____

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Emergency medications for Potential Acute Infusion Reactions

- ☐ Anaphylaxis Kit per ***Amber Specialty Pharmacy Home infusion anaphylaxis treatment protocol***
- ☐ Albuterol Inhaler to be used as needed for severe respiratory reactions
- ☐ Solu-Medrol 125mg/2 ml IV be used as needed for severe respiratory reactions and/or anaphylactic reactions (e.g. Angioedema) as instructed by Physician.

Anaphylaxis Kit Contents
Epinephrine 1mg Vial (1:1000 USP) Diphenhydramine HCL (50 mg/1mL vial) 0.9% Sodium Chloride (500 mL) 2x 1ml syringe w/25g 1" needle 2x 3ml syringe w/25g 1.5" needle, Non-vented IV Set Alcohol wipes

Vascular Access Device (VAD) Orders:

Peripheral Vascular Access Device: Skilled nursing to assess and insert peripheral access device for administration of Bamalanivimab/Etesevimab.
Other: _____

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/Etesevimab, patient assessment, and monitoring.

- Document Vital Signs: Temperature, HR, RR, Pulse Ox taken before medication initiation; immediately after medication administration; and 1 hour post medication administration
- Medical professional to monitor patient 1-hour post medication administration
- Document time of medication administration
- Note any adverse reactions

Physician Signature: _____ Printed:_____ Date:_____

Vital Sign	Prior to Med Administration	Immediately after Med Administration	1 Hour Post Medication Administration
Temp			
HR			
RR			