AMBER™ SPECIALTY PHARMACY

Phone: 888.370.1724
Fax: 855.370.0086

# REGEN-COV (Casirivimab with Imdevimab) 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 Casirivimab with Imdevimab 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

**Inclusion Criteria**: **The following criteria are required to qualify a patient for Casirivimab with Imdevimab therapy**

**Check all that apply:**

☐ Patient is 12 years of age or older weighing at least 40 kg who are at high risk (see criteria below) for progression to severe COVID-19, including hospitalization or death, and are not fully vaccinated **or** who are not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination (for example, individuals with immunocompromising conditions including those taking immunosuppressive medications)

**and**

**Prophylaxis Patients only:**

☐ have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per Centers for Disease Control and Prevention (CDC) **or**
☐ who are at high risk of exposure to an individual infected with SARS-CoV-2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, nursing homes, prisons)

**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)**:

☐ Older age (for example, age ≥65 years of age)
☐ Obesity or being overweight (for example, BMI >25 kg/m2 , or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)
☐ 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)
☐ Other medical conditions or factors that may place individual patients at high risk for severe COVID-19: _____

Physician Signature: _____ Printed:_____ Date:_____

## *IV Infusion Orders*

- ☐ ***Casirivimab 600mg with Imdevimab 600mg in 100 mL 0.9% Sodium Chloride*** to be infused IV via gravity or infusion pump over 30 minutes x 1 dose
  (Must use a 0.2 or 0.22 micron filter for administration)
- ☐ **Subsequent Repeat Dosing:** For patients in whom repeat dosing is determined to be appropriate for ongoing exposure to SARS-CoV-2 for longer than 4 weeks and who are not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination
- ☐ The initial intravenous infusion may be followed by subsequent repeat dosing of 300 mg of Casirivimab and 300 mg of Imdevimab by IV infusion once every 4 weeks for the duration of ongoing exposure.
- ☐ ***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.
- ☐ Clinically monitor patients during infusion and observe patients for at least 1 hour after infusion is complete.

**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/2mL 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)*<br>*Diphenhydramine HCL (50 mg/1mL vial)*<br>*0.9% Sodium Chloride (500 mL)*<br>*2 x 1mL syringe w/ 25G x 1" needle* | *2 x 3mL syringe w/ 25G x 1.5" needle,*<br>*Non-vented IV Set*<br>*Alcohol wipes* |

***Vascular Access Device (VAD) Orders:***

Peripheral Vascular Access Device: Skilled nursing to assess and insert peripheral access device for administration of Casirivimab with Imdevimab.

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 Casirivimab with Imdevimab, patient assessment, and monitoring.

Physician Signature: _____ Printed:_____ Date:_____

## *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

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