HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Patient Information:
Name:_____
DOB: _____

Pediatric COVID-19 Monoclonal Antibody Referral Form

*This form must be completed by the referring provider and will be uploaded as a PDF to the patient's chart in EPIC via Media Manager function Complete the required fields (annotated by *) and submit this referral form along with the order form (page 2)*
*via fax to: **859-218-7670***

Indication*: *patient must meet both of the below criteria in addition to others listed below*
This patient is:
☐ 12 years of age or older
☐ At least 40 kg (documented weight: ____ kg (date obtained: _____ (MM/DD/YYYY))

☐ **Treatment** *(if selected, complete the below fields)*
1. ☐ Mild to moderate COVID-19 infection with **positive** results of direct SARS-CoV-2 viral testing (PCR or antigen):
   - Date of SARS-CoV-2 Test: _____ (MM/DD/YYYY)
   - Date of Symptom Onset:_____ (MM/DD/YYYY)

   AND
2. ☐ At least **two** of the following symptoms: *select all that apply*
   ☐ Fever ☐ Cough ☐ Sore Throat
   ☐ Malaise ☐ Headache ☐ Myalgias
   ☐ Gastrointestinal Symptoms
   ☐ Shortness of Breath ☐ Other: _____

☐ **Post-Exposure Prophylaxis** *(if selected, complete the below fields)*
1. ☐ Not fully vaccinated **OR**
   ☐ Not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination

   AND
2. ☐ Have been exposed to an individual infected with SARS CoV-2 consistent with close contact criteria per CDC **OR**
   ☐ Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of an occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting

Select the Patient's High Risk Criteria* outlined in the EUA include the following:
☐ Obesity or being overweight (BMI ≥ 85% for their age and gender on CDC growth charts)
☐ Chronic kidney disease
☐ Diabetes
☐ Immunosuppressive disease or immunosuppressive treatment
☐ Cardiovascular disease (including congenital heart disease)
☐ Sickle cell disease
☐ Pregnant
☐ Chronic lung disease (moderate to severe asthma, interstitial lung disease, cystic fibrosis and pulmonary hypertension)
☐ Neurodevelopmental disorders or other conditions that confer medical complexity (i.e., cerebral palsy, genetic/metabolic syndromes, severe congenital anomalies)
☐ Medical-related technological dependent (i.e., tracheostomy, gastrostomy, positive pressure ventilation not related to COVID-19)
☐ Other medical conditions/factors associated with increased risk for progression to severe COVID, per CDC website
If other, please specify: _____

☐ **I have provided the patient's legal guardian with a copy of the Fact Sheet for Parents and Caregivers** (English; Spanish)*

Legal Attestation*:

_____(Last Name, First Name) is a _____ (age) year old _____ (gender) under my care for COVID-19. I have assessed my patient as eligible to receive casirivimab and imdevimab under the FDA Emergency Use Authorization (EUA). I have reviewed the mandatory requirements for drug use within the Fact Sheet for Health Care Providers and obtained approval for use according to institutional policy. I have provided information consistent with the Fact Sheet for Patients and Parents/Caregivers EUA of casirivimab and imdevimab and given the patient/legal representative a copy. The patient/legal representative was informed of the potential risks and benefits of casirivimab and imdevimab, alternatives to casirivimab and imdevimab, and that casirivimab and imdevimab is an unapproved drug that is authorized for use under EUA. The patient or patient's legal representative has expressly agreed to this treatment.

_____	_____	_____
Signature, Referring Provider	Date (MM/DD/YYYY)	Contact Information

HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Pediatric COVID-19 Monoclonal Antibody Order Form

Complete the required fields (annotated by *) and submit this order form along with the referral form (page 1) via fax to: **859-218-7670**

Patient Name*: _____ **Date of Birth*:** _____

Legal Guardian Name*: _____ **Phone Number*:** _____

Allergies*: _____

☐ No Known Drug Allergies

Indication*:

☐ Treatment

☐ Post-Exposure Prophylaxis

Casirivimab/Imdevimab Order:

Intravenous Administration

☒ casirivimab 600 mg, imdevimab 600 mg in sodium chloride 0.9% 100 mL IV piggyback administered over 30 minutes

If intravenous access cannot be obtained the subcutaneous order will be activated for use as selected below

Subcutaneous Administration

☒ casirivimab 300 mg (2.5 mL) subcutaneous every 5 minutes for 2 doses as needed for intravenous access difficulty

AND

☒ imdevimab 300 mg (2.5 mL) subcutaneous every 5 minutes for 2 doses as needed for intravenous access difficulty

Additional Drug Therapy Orders:

☒ lidocaine (Anecream) 1 application topically as needed for line insertion **OR**

☒ lidocaine (Anecream) 4 applications topically as needed for subcutaneous injections

Nursing Orders:

☒ Insert peripheral IV

☒ Clinically monitor patient during administration and observe patient for at least 1 hour after administration is complete; monitor vital signs at baseline, at end of the administration and 1 hour after administration is completed

Hypersensitivity Orders:

☒ Hypersensitivity Management per University of Kentucky HealthCare Protocol

☒ hydrocortisone ____ *mg (2 mg/kg (max: 100 mg)) intravenous **or** prednisolone ____ *mg (2 mg/kg (max: 60 mg)) oral as needed for Grade 2, 3 or 4 infusion reactions

☒ diphenhydramine ____ *mg (1 mg/kg (max: 50 mg)) intravenous/oral as needed for Grade 2, 3 or 4 infusion reactions

☒ famotidine 20 mg (0.5 mg/kg (max: 20 mg)) intravenous/oral as needed for Grade 2, 3 or 4 infusion reactions

☒ albuterol 108 (90 base) mcg/act inhaler 4 puffs as needed for Grade 3 or 4 infusion reactions

☒ epinephrine 0.3 mg intramuscular as needed for Grade 4 infusion reactions

_____	_____	_____
Signature, Referring Provider	Date (MM/DD/YYYY)	Telephone Number
_____	_____	_____/_____
Printed Name, Referring Provider	Credentials	License Number/DEA Number

_____	_____	_____	_____
Address	City	State	Zip Code

Updated: 09/22/2021

Pediatric COVID-19 Monoclonal Antibody Outpatient Therapy Workflow for Outside Referrals

Patients, regardless of where they test positive, may have the therapy ordered after they speak with their provider, assuming they qualify. The product is currently provided at no cost from the manufacturer, so the only charge is for the chair time in the infusion suite

Emergency use of casirivimab/imdevimab has been authorized by the Food and Drug Administration (FDA). As casirivimab/imdevimab is not FDA approved for this defined patient population, the following fact sheet containing drug information should be carefully reviewed when considering use: Casirivimab/Imdevimab EUA - Fact Sheet for Healthcare Providers

Dosing:

- For Post-Exposure Prophylaxis AND Treatment: 600 mg of casirivimab AND 600 mg of imdevimab
  - The preferred route of administration will be intravenously [if peripheral intravenous access cannot be obtained, subcutaneous administration will be used]
  - Clinically monitor patients during treatment administration (regardless of route) and for at least **1 hour** after dosing is complete

Screening and Selection of Appropriate Candidates:

It is important to note that COVID-19 does not affect all population groups equally.

- The risk of severe COVID-19 increases as the number of underlying medical conditions increases in an individual.
- Long-standing systemic health and social inequities have put various groups of people at increased risk of getting sick and dying from COVID-19, including many **racial and ethnic minority groups** and **people with disabilities**

Inclusion Criteria:

- Pediatric patients 12 to < 18 years of age **AND** weighing at least 40 kg meeting high risk criteria (below) for developing a severe COVID-19 infection and are currently outpatient and **not** hospitalized for COVID-19 (as listed per exclusion criteria below)

Treatment	Post-Exposure Prophylaxis
Mild-to-moderate COVID-19 infection with positive results of direct SARS-CoV-2 viral testing (PCR or antigen) with the following: • Symptomatic (at least 2 of the following: fever, cough, sore throat, malaise, headache, myalgias, gastrointestinal symptoms, shortness of breath) • Within 10 days of symptom onset	Not fully vaccinated OR who are not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination **AND** • Have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per CDC **or** • Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of an occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting

High risk criteria outlined in the EUA include the following:

- Obesity or being overweight (BMI ≥ 85% for their age and gender on CDC growth charts)
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease)
- Sickle cell disease
- Pregnant
- Chronic lung disease (moderate to severe asthma, interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- Neurodevelopmental disorders or other conditions that confer medical complexity (i.e., cerebral palsy, genetic/metabolic syndromes, severe congenital anomalies)
- Medical-related technological dependent (i.e., tracheostomy, gastrostomy, positive pressure ventilation not related to COVID-19)
- Other medical conditions/factors associated with increased risk for progression to severe COVID, per CDC website

Exclusion Criteria:

- Hospitalization due to COVID-19
- Requiring oxygen therapy due to COVID-19, including those patients on chronic oxygen therapy who require an increase in baseline oxygen flow rate due to COVID-19
- Hypersensitivity to product or ingredients
- Co-morbidity requiring surgery within 7 days or considered life threatening within 29 days

Casirivimab/Imdevimab Infusion Referral Process: *Patients will be scheduled as referrals are received, with priority given to patients receiving casirivimab/imdevimab for the mild-to-moderate symptomatic COVID-19 infection treatment indication*

Process	Responsible Party
Patient is deemed candidate for casirivimab/imdevimab as treatment or post-exposure prophylaxis upon review of patient specific criteria outlined above per the EUA	Referring Provider
↓	
Legal Guardian is informed of alternatives to receiving casirivimab/imdevimab and that casirivimab/imdevimab is an unapproved drug authorized for use under FDA EUA. Legal Guardian is counseled and provided with Fact Sheet for Parents and Caregivers (English; Spanish)	Referring Provider
↓	
Complete and sign the casirivimab/imdevimab EUA criteria referral **and** order forms and submit to 859-218-7670. [Tip Sheet Found on Website]	Referring Provider
↓	
Upon receipt of referral and order forms, scheduling staff will register the patient in to EPIC. The scheduler will call patient/legal guardian and schedule infusion appointment at next available infusion date and time. During this call, the scheduler will provide guidance to the patient/legal guardian on parking, registration, and arrival.	Designated Scheduler
↓	
Scheduler will be upload the completed referral and order forms to the patient's medical record through EPIC "Media Manager".	Designated Scheduler
↓	
Within 48 to 72 hours of casirivimab/imdevimab infusion, the patient must have a documented telehealth visit in order to evaluate clinical status and ensure no disease progression or escalation of care is warranted.	Referring Provider
↓	
Within 7 to 10 days of casirivimab/imdevimab infusion, the referring provider or designee (i.e., RN) completes a telephone call with patient or caregiver to evaluate clinical status and ensure no disease progression or escalation of care is warranted.	Referring Provider or Designee (i.e., Nurse)
↓	
Report all medication errors and adverse events occurring during casirivimab/imdevimab use and consider potentially attributable to casirivimab/imdevimab within 7 calendar days from onset of event: • UKHC SI Report (reported through this system only if reaction occurs at UKHC) • FDA MedWatch: www.fda.gov/medwatch/report.htm ○ Follow all instructions for reporting within the EUA Prescribing Information Listed in the Health Care Provider Fact Sheet	Any Patient Care Provider (i.e., Referring Provider, Pharmacist, Nurse, etc.)

Tip Sheet

COMPLETING THE REQUIRED PEDIATRIC COVID-19 MONOCLONAL ANTIBODY REFERRAL FORM

Step 1: Complete the Patient Specific Information

UK HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Patient Information:
Name: _____
DOB: _____

Pediatric COVID-19 Monoclonal Antibody Referral Form

*This form must be completed by the referring provider and will be uploaded as a PDF to the patient's chart in EPIC via Media Manager function Complete the required fields (annotated by *) and submit this referral form along with the order form (page 2) via fax to:* **859-218-7670**

Step 2: Review patient specific information to confirm that patient meets the Emergency Use Authorization (EUA) criteria as outlined in the *Interim Guidance for the Outpatient Management of SARS-CoV-2 (COVID-19) with Monoclonal Antibody Therapy in Pediatric Patients*

- **Step 2a:** Indicate that the patient is 12 years of age or older **AND** weights at least 40 kg (list the patient's weight and date in which that weight was obtained)

These boxes can be selected within the PDF or simply annotate with a check mark (√) or X

Indication: *patient must meet both of the below criteria in addition to others listed below*
This patient is:
☐ 12 years of age or older **AND**
☐ At least 40 kg (documented weight: ____kg (date obtained: _____(MM/DD/YYYY))

- **Step 2b:** Indicate the specific indication for use: **treatment** or **post-exposure prophylaxis**. Based on the indication selected, complete the required fields

Treatment **OR** Post-Exposure Prophylaxis

☐ **Treatment** *(if selected, complete the below fields)*

1. ☐ Mild to moderate COVID-19 infection with **positive** results of direct SARS-CoV-2 viral testing (PCR or antigen):
   - Date of SARS-CoV-2 Test: _____ (MM/DD/YYYY)
   - Date of Symptom Onset:_____ (MM/DD/YYYY)

AND

2. ☐ At least **two** of the following symptoms: *select all that apply*
   ☐ Fever ☐ Cough ☐ Sore Throat
   ☐ Malaise ☐ Headache ☐ Myalgias
   ☐ Gastrointestinal Symptoms
   ☐ Shortness of Breath ☐ Other: _____

Complete Item 1 **and** 2

☐ **Post-Exposure Prophylaxis** *(if selected, complete the below fields)*

1. ☐ Not fully vaccinated **OR**
   ☐ Not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination

AND

2. ☐ Have been exposed to an individual infected with SARS CoV-2 consistent with close contact criteria per CDC **OR**
   ☐ Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of an occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting

Select an Item in 1 **and** 2

Tip Sheet

- **Step 2c:** Select the high risk criteria that align with the being referred for monoclonal antibody administration

Select the Patient's High Risk Criteria outlined in the EUA include the following:

- ☐ Obesity or being overweight (BMI ≥ 85% for their age and gender on CDC growth charts)
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease or immunosuppressive treatment
- ☐ Cardiovascular disease (including congenital heart disease)
- ☐ Sickle cell disease
- ☐ Pregnant
- ☐ Chronic lung disease (moderate to severe asthma, interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- ☐ Neurodevelopmental disorders or other conditions that confer medical complexity (i.e., cerebral palsy, genetic/metabolic syndromes, severe congenital anomalies)
- ☐ Medical-related technological dependent (i.e., tracheostomy, gastrostomy, positive pressure ventilation not related to COVID-19)
- ☐ Other medical conditions/factors associated with increased risk for progression to severe COVID, per CDC website
  If other, please specify: _____

REMINDER: These boxes can be selected within the PDF or simply annotate with a check mark (√) or X

- **Step 2d:** Attest that you have provided the patient's legal guardian with the Fact Sheet. This is a requirement per EUA criteria!

☐ **I have provided the patient's legal guardian with a copy of the Fact Sheet for Parents and Caregivers** (English; Spanish)

To attest, simply annotate this box within the PDF formatting or annotate with a check mark (√) or X

Links are available to the fact sheet here!

Step 3: Complete the legal attestation that has been previously reviewed and approved for EUA therapies offered at UK HealthCare – this includes COVID-19 monoclonal antibody therapy!

Legal Attestation:

_____ (Last Name, First Name) is a _____ (age) year old _____ (gender) under my care for COVID-19. I have assessed my patient as eligible to receive casirivimab and imdevimab under the FDA Emergency Use Authorization (EUA). I have reviewed the mandatory requirements for drug use within the Fact Sheet for Health Care Providers and obtained approval for use according to institutional policy. I have provided information consistent with the Fact Sheet for Patients and Parents/Caregivers EUA of casirivimab and imdevimab and given the patient/legal representative a copy. The patient/legal representative was informed of the potential risks and benefits of casirivimab and imdevimab, alternatives to casirivimab and imdevimab, and that casirivimab and imdevimab is an unapproved drug that is authorized for use under EUA. The patient or patient's legal representative has expressly agreed to this treatment.

Step 4: Sign, date, and list contact information as the referring provider. This signature can be completed through a digital signature **OR** alternative means of legal signature (i.e., ink or stamp)

_____ Signature, Referring Provider

_____ Date (MM/DD/YYYY)

_____ Contact Information

Tip Sheet

COMPLETING THE REQUIRED PEDIATRIC COVID-19 MONOCLONAL ANTIBODY ORDER FORM

Step 1: Complete the Patient Specific Information, including the name and contact information of the patient's legal guardian [this information will be needed for scheduling purposes!]

HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Pediatric COVID-19 Monoclonal Antibody Order Form

*Complete the required fields (annotated by *) and submit this order form along with the referral form (page 1) via fax to:* **859-218-7670**

Patient Name*: _____ **Date of Birth*:** _____

Legal Guardian Name*: _____ **Phone Number*:** _____

Allergies*: _____

☐ No Known Drug Allergies

Step 2: Select the appropriate indication (this should be the same indication as page 1)

Indication*:

☐ Treatment

☐ Post-Exposure Prophylaxis

To attest, simply annotate this box within the PDF formatting or annotate with a check mark (√) or X

Step 3: Review the selected orders for casirivimab/imdevimab – these have already been selected for you based on current workflow at UK HealthCare.

Casirivimab/Imdevimab Order:

Intravenous Administration

☒ casirivimab 600 mg, imdevimab 600 mg in sodium chloride 0.9% 100 mL IV piggyback administered over 30 minutes

If intravenous access cannot be obtained the subcutaneous order will be activated for use as selected below

Subcutaneous Administration

☒ casirivimab 300 mg (2.5 mL) subcutaneous every 5 minutes for 2 doses as needed for intravenous access difficulty

AND

☒ imdevimab 300 mg (2.5 mL) subcutaneous every 5 minutes for 2 doses as needed for intravenous access difficulty

Additional Drug Therapy Orders:

☒ lidocaine (Anecream) 1 application topically as needed for line insertion **OR**

☒ lidocaine (Anecream) 4 applications topically as needed for subcutaneous injections

Nursing Orders:

☒ Insert peripheral IV

☒ Clinically monitor patient during administration and observe patient for at least 1 hour after administration is complete; monitor vital signs at baseline, at end of the administration and 1 hour after administration is completed

- **Step 3a:** Be sure to complete the patient specific dosing for the hypersensitivity kit medications – **hydrocortisone, prednisolone** and **diphenhydramine**

Hypersensitivity Orders:

☒ ~~Hypersensitivity Management per University of Kentucky HealthCare Protocol~~
☒ hydrocortisone ____ *mg (2 mg/kg (max: 100 mg)) intravenous **or** prednisolone ____ *mg (2 mg/kg (max: 60 mg)) oral as needed for Grade 2, 3 or 4 infusion reactions
☒ diphenhydramine ____ *mg (1 mg/kg (max: 50 mg)) intravenous/oral as needed for Grade 2, 3 or 4 infusion reactions
☒ famotidine 20 mg (0.5 mg/kg (max: 20 mg)) intravenous/oral as needed for Grade 2, 3 or 4 infusion reactions
☒ albuterol 108 (90 base) mcg/act inhaler 4 puffs as needed for Grade 3 or 4 infusion reactions
☒ epinephrine 0.3 mg intramuscular as needed for Grade 4 infusion reactions

Step 4: Sign, date, and list contact information (including address) along with credentials, license number and DEA number as the referring provider. This signature can be completed through a digital signature **OR** alternative means of legal signature (i.e., ink or stamp)

Signature, Referring Provider | Date (MM/DD/YYYY) | Telephone Number

Printed Name, Referring Provider | Credentials | License Number/DEA Number

Address | City | State | Zip Code

Once Page 1 (Referral Form) and Page 2 (Order Form) are completed, fax to 859-218-7670. A team member will contact your patient (or patient's legal guardian) to schedule their infusion.

These forms can be printed and the information completed by hand or the referral and order form can be digitally completed and signed.

See Page 5 and 6 for Example COMPLETED Documents

HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Patient Information:
Name:_____
DOB: _____

Pediatric COVID-19 Monoclonal Antibody Referral Form

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via fax to: **859-218-7670**

Indication*: *patient must meet both of the below criteria in addition to others listed below*
This patient is:
☐ 12 years of age or older
☐ At least 40 kg (documented weight: 85 kg (date obtained: _____ (MM/DD/YYYY))

☐ **Treatment** *(if selected, complete the below fields)*
1. ☐ Mild to moderate COVID-19 infection with **positive** results of direct SARS-CoV-2 viral testing (PCR or antigen):
   - Date of SARS-CoV-2 Test: _____ (MM/DD/YYYY)
   - Date of Symptom Onset:_____ (MM/DD/YYYY)

AND

2. ☐ At least **two** of the following symptoms: *select all that apply*
   ☐ Fever ☐ Cough ☐ Sore Throat
   ☐ Malaise ☐ Headache ☐ Myalgias
   ☐ Gastrointestinal Symptoms
   ☐ Shortness of Breath ☐ Other: _____

☐ **Post-Exposure Prophylaxis** *(if selected, complete the below fields)*
1. ☐ Not fully vaccinated **OR**
   ☐ Not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination

AND

2. ☐ Have been exposed to an individual infected with SARS CoV-2 consistent with close contact criteria per CDC **OR**
   ☐ Who are at high risk of exposure to an individual infected with SARS-CoV-2 because of an occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting

859-218-7670

Select the Patient's High Risk Criteria* outlined in the EUA include the following:
☐ Obesity or being overweight (BMI ≥ 85% for their age and gender on CDC growth charts)
☐ Chronic kidney disease
☐ Diabetes
☐ Immunosuppressive disease or immunosuppressive treatment
☐ Cardiovascular disease (including congenital heart disease)
☐ Sickle cell disease
☐ Pregnant
☐ Chronic lung disease (moderate to severe asthma, interstitial lung disease, cystic fibrosis and pulmonary hypertension)
☐ Neurodevelopmental disorders or other conditions that confer medical complexity (i.e., cerebral palsy, genetic/metabolic syndromes, severe congenital anomalies)
☐ Medical-related technological dependent (i.e., tracheostomy, gastrostomy, positive pressure ventilation not related to COVID-19)
☐ Other medical conditions/factors associated with increased risk for progression to severe COVID, per CDC website
If other, please specify: _____

☐ **I have provided the patient's legal guardian with a copy of the Fact Sheet for Parents and Caregivers** (English; Spanish)*

Legal Attestation*:

_____(Last Name, First Name) is a _____ (age) year old _____ (gender) under my care for COVID-19. I have assessed my patient as eligible to receive casirivimab and imdevimab under the FDA Emergency Use Authorization (EUA). I have reviewed the mandatory requirements for drug use within the Fact Sheet for Health Care Providers and obtained approval for use according to institutional policy. I have provided information consistent with the Fact Sheet for Patients and Parents/Caregivers EUA of casirivimab and imdevimab and given the patient/legal representative a copy. The patient/legal representative was informed of the potential risks and benefits of casirivimab and imdevimab, alternatives to casirivimab and imdevimab, and that casirivimab and imdevimab is an unapproved drug that is authorized for use under EUA. The patient or patient's legal representative has expressly agreed to this treatment.

_____ _____ _____
Signature, Referring Provider | Date (MM/DD/YYYY) | Contact Information

HealthCare
KENTUCKY CHILDREN'S HOSPITAL

Pediatric COVID-19 Monoclonal Antibody Order Form

Complete the required fields (annotated by *) and submit this order form along with the referral form (page 1) via fax to: **859-218-7670**

Patient Name*: _____ **Date of Birth*:** _____

Legal Guardian Name*: _____ **Phone Number*:** _____

Allergies*: _____

☐ No Known Drug Allergies

Indication*:

☐ Treatment

☐ Post-Exposure Prophylaxis

Casirivimab/Imdevimab Order:

Intravenous Administration

☒ casirivimab 600 mg, imdevimab 600 mg in sodium chloride 0.9% 100 mL IV piggyback administered over 30 minutes

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Nursing Orders:

☒ Insert peripheral IV

☒ Clinically monitor patient during administration and observe patient for at least 1 hour after administration is complete; monitor vital signs at baseline, at end of the administration and 1 hour after administration is completed

Hypersensitivity Orders:

☒ Hypersensitivity Management per University of Kentucky HealthCare Protocol

☒ hydrocortisone ____ *mg (2 mg/kg (max: 100 mg)) intravenous **or** prednisolone ____ *mg (2 mg/kg (max: 60 mg)) oral as needed for Grade 2, 3 or 4 infusion reactions

☒ diphenhydramine ____ *mg (1 mg/kg (max: 50 mg)) intravenous/oral as needed for Grade 2, 3 or 4 infusion reactions

☒ famotidine 20 mg (0.5 mg/kg (max: 20 mg)) intravenous/oral as needed for Grade 2, 3 or 4 infusion reactions

☒ albuterol 108 (90 base) mcg/act inhaler 4 puffs as needed for Grade 3 or 4 infusion reactions

☒ epinephrine 0.3 mg intramuscular as needed for Grade 4 infusion reactions

_____	_____	_____
Signature, Referring Provider	Date (MM/DD/YYYY)	Telephone Number
_____	_____	_____/_____
Printed Name, Referring Provider	Credentials	License Number/DEA Number

_____	_____	_____	_____
Address	City	State	Zip Code

Updated: 09/22/2021