Goshen Health

Monoclonal Antibody Order Form

Patient Name: _____ **Patient DOB:** _____

Patient Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Patient Email: _____ **Patient Phone:** _____

Patient Allergies: _____

Patient Diagnosis: **COVID – 19** **Date of Symptom Onset:** _____

Last date eligible for monoclonal antibody infusion (10 days from symptom onset): _____

Monoclonal Antibody Emergency Use Authorization (EUA) Criteria:

The EUA is for the use of the unapproved monoclonal antibody infusions for the treatment of mild to moderate COVID-19 in adult and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are at high risk for progressing to severe COVID-19 and/or hospitalization.

High risk is defined as patients who meet at least one of the following criteria (check the qualifying condition for this patient). For additional information on high-risk patients visit https://www.cdc.gov/coronavirus/2019 ncov/need extraprecautions/people with medical conditions.html:

- ☐ Older age (for example age ≥65 years of age)
- ☐ Obesity or being overweight, for example: Adults with body mass index (BMI) > 25 kg/m2, children age 12-17 with a BMI ≥85th percentile for their age and gender based on CDC growth charts
- ☐ 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, moderate to severe asthma, 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 condition(s) or factor(s) that increase progression to severe COVID-19, including hospitalization or death.

Inclusion criteria (all must be true to qualify for therapy):

☐ Not currently hospitalized due to COVID-19
☐ Not initiated on oxygen therapy due to COVID-19
☐ For those on chronic oxygen therapy, baseline oxygen flow rate was not increased due to COVID-19
☐ Patient ≥ 12 years old
☐ Patient ≥ 40 kg
☐ Patient has a positive COVID test result **(Date: _____)**

Consent Statement:

☐ As the patient's healthcare provider, I have communicated to the patient or parent/caregiver listed above, as age appropriate, the information consistent with the "Fact Sheet for Patients, Parents and Caregivers" prior to the patient receiving monoclonal antibody products. I have documented in the patient's medical record that the patient/caregiver has been:

1. Given the "Fact Sheet for Patients, Parents and Caregivers" The fact sheet can also be accessed at: https://www.fda.gov/media/143893/download
2. Informed of alternatives to receiving monoclonal antibodies, and
3. Informed that monoclonal antibodies are unapproved drugs that are authorized for use under Emergency Use Authorizations.

Drug Order:

☐ Casirivimab 600 mg & Imdevimab 600 mg **IV once over 1 hour**. Observe for 1 hour following infusion, and then discharge. Treat any allergic or infusion reactions per protocol.

☐ Casirivimab 600 mg & Imdevimab 600 mg **SQ once (4 x 2.5 ml injections)**. Observe for 1 hour following injection, and then discharge. Treat any allergic or infusion reactions per protocol.

Provider Signature: _____ **Date:** _____ **Time:** _____

Provider Printed Name: _____

Provider Phone #: _____ **Provider Fax #:** _____

Appointment Date: _____ **Appointment Time:** _____

Communicated with Patient Date: _____ **Time:** _____

ONCE COMPLETD, PLEASE FAX OR EMAIL TO:

Goshen Cancer Center Infusion Center
200 High Park Ave
Goshen, IN 46526
Fax: 574-364-2983 / Phone: 574-364-2597
Email: infusioncenter@goshenhealth.com