Pharmacy
HyVee SOLUTIONS

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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 bamlanivimabtherapy)

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 chronicoxygen 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 viagravity 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 ensuredelivery of required dose.

Physician Signature:_____printed:_____ Date:_____

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Emergency medications for Potential Acute Infusion Reactions

- ☐ Anaphylaxis Kit per ***Amber 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			