Omnicare®
a CVSHealth company

Casirivimab/Imdevimab Infusion Intake/Prescriber Order

Prescriber agrees:

- ☑ I understand this drug is not authorized for use in hospitalized coronavirus disease 2019 (COVID-19) patients, patients requiring oxygen therapy due to COVID-19, patients who require an increase in baseline oxygen flow rate due to COVID-19 and the patient or his/her guardian have provided their informed consent for the administration of Casirivimab/Imdevimab.
- ☑ I understand Casirivimab/Imdevimab should only be used for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older weighing at least 40 kg, and who are at high risk for progressing to severe COVID-19 and/or hospitalization, and when the known and potential benefits to patients outweigh the known and potential risks of such product.

Patient Information

Patient Name		Date of Birth	Gender ☐ Male ☐ Female
Facility	Room/Bed	Height	Weight

Clinical Information

Date of positive COVID-19 test result	Date of symptom onset and disease manifestation

Adult Patient meets at least one of the following criteria *(Check all that apply)*

- ☐ Has a body mass index (BMI) ≥35
- ☐ Has chronic kidney disease
- ☐ Has diabetes
- ☐ Has immunosuppressive disease
- ☐ Is currently receiving immunosuppressive treatment
- ☐ Is ≥65 years of age

OR

- ☐ Patient is ≥55 years of age **AND** has ☐ Cardiovascular disease **OR** ☐ Hypertension **OR**
- ☐ Chronic obstructive pulmonary disease/other chronic respiratory disease

Orders

- ☐ Establish vascular access, if needed (peripheral IV)
- ☐ Casirivimab 1200mg/Imdevimab 1200 mg IV in 250 mL 0.9% Sodium Chloride administered over at least 60 minutes
- ☐ Follow infusion with 0.9 % Sodium Chloride 25 mL to infuse at same rate as infusion to clear administration set of drug post infusion
- ☐ 0.9% Sodium Chloride 10 mL flush PRN
- ☐ Acute infusion reaction orders: **PHARMACY TO PROVIDE IN ANAPHYLAXIS E KIT**

Check	Drug or Treatment	Severity	Over 30 kg	Route	Note
☐	Epinephrine 1 mg/mL amp (1:1000)	Moderate to Severe	☐ 0.3 mg	☐ SQ ☐ IM	☐ Repeat in 3-5 mins PRN
☐	Diphenhydramine Oral	Mild	☐ 25 mg ☐ 50 mg	PO	
☐	Diphenhydramine 50mg/mL vial	Moderate to Severe	☐ 25 mg ☐ 50 mg	Slow IV or IM	☐ Repeat in 3-5 mins PRN MAX dose = 50 mg
☐	Methylprednisolone Sodium Succinate 125mg/2mL	Moderate to Severe	125 mg	☐ IM ☐ IV	x 1 dose
☐	Albuterol inhaler	Moderate to Severe	90 mcg/act	INHALER	1-2 puffs PRN

Facility Nurse to call/fax above information to physician/LIP. Either have physician/LIP sign below, or obtain as a telephone order.

Nurse	Print Name	Date
Physician/prescriber	Print Name	Date

Pharmacy Name: _____ **FAX COMPLETED FORM TO (** _____ **)** _____ **-** _____

PLEASE NOTE: PHARMACY MAY REQUIRE ADDITIONAL INFORMATION BEFORE ORDERS CAN BE PROCESSED.