Monoclonal Antibody Infusion Clinic
201 Lew Dewitt Blvd, Waynesboro VA 22980
Phone: (540) 245-7040 Fax: (540) 245-7959

Casirivimab/Imdevimab (REGEN-COV™) ORDER SHEET

Patient will receive an outpatient appointment. DO NOT SEND PATIENT TO THE HOSPITAL

REGEN-COV™ *is authorized by FDA for the emergency use for treatment of individuals with mild to moderate COVID-19 who are at high risk for progressing to severe COVID-19 and/or hospitalization as defined in the EUA.*

Patient Name: _____

Date of Birth: _____ Age: _____ Patient Contact Number: _____

Date of COVID-19 symptom onset (infusion must be within 10 days): _____

Date of positive COVID-19 test:_____

Does this patient:

- ☐ Require hospitalization due to COVID-19
- ☐ Require oxygen therapy due to COVID-19
- ☐ Require an increase in baseline oxygen flow rate due to COVID-19 for patients that require oxygen at baseline due to underlying non-COVID-19 comorbidity
- ☐ Have an age less than 18 years old
- ☐ Weigh less than 40 kg

*****If any box is checked, STOP- this patient is not eligible for therapy*****

Risk factors (please check all that apply)

ADULTS (age ≥ 18) and have at least one of the below criteria:

- ☐ Are ≥ 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)
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease or currently receiving immunosuppressive treatment
- ☐ Pregnancy
- ☐ Cardiovascular 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)

Physician Signature: _____ Date/Time: _____

Physician Printed Name: _____

Fax this request to: (540) 245-7951

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Patient Name: _____ Date of Birth: _____

For Monoclonal Infusion Clinic Use Only:

I attest that I have:

- ☐ I attest that the patient meets the requirements for treatment as put forth by the Regen-COV™ EUA.
- ☐ Provided the patient or parent/caregiver with the "Fact Sheet for Patients, Parents, and Caregivers".
- ☐ I have informed the patient or parent/caregiver that this medication is available as an unapproved drug that is authorized for use under an EUA and discussed information consistent with the EUA, as noted:
  - The patient or parent/caregiver has the option to accept or refuse Regen-COV™
  - The significant known and potential risks and benefits of Regen-COV™, and the extend to which such potential risks and benefits are unknown
  - Information on available alternative treatments and the risks and benefits of those alternative treatments, including clinical trials
  - Patients treated with Regen-COV™ should continue to self-isolate and use infection control measures according to the CDC guidelines

If the patient has one (1) or more risk factors for progression to severe COVID-19 and the above attestations are met, proceed with treatment:

1. Obtain vitals upon start of infusion and check vitals every 15 minutes while receiving treatment.
2. Place peripheral IV and discontinue IV prior to departure.
3. Casirivimab 600 mg and Imdevimab 600 mg IV infusion in 0.9% Sodium Chloride 100 mL, infused over 30 min, at a rate of 250 mL/hour, Once.
4. Flush line with normal saline after the end of infusion.
5. Observe and monitor patient for at least 1 hour following the end of infusion.
6. Obtain vitals every 15 minutes x 4 post infusion.
7. May discharge if patient has stable vitals similar to the patient's baseline status on arrival.

PRN for Hypersensitivity

Diphenhydramine 25-50 mg IVP PRN X 1 dose
Epinephrine 0.3 mg IM PRN X 1 dose
Methylprednisolone 125 mg IVP PRN X 1 dose

PRN for pain/fever above 38^0 C

Acetaminophen 650 mg PO PRN X 1 dose

Physician Signature: _____ Date/Time: _____

Physician Printed Name: _____