Beaumont

COVID-19 Monoclonal Antibody Treatment Order

FAX COMPLETED FORM TO: 947-522-5050 Select Preferred Site: ☐ Troy ☐ Lenox

Patient Name_____ Date of Birth: _____ MRN: _____

Date of COVID-19 Symptom Onset: _____ Date of Positive COVID-19 Test: _____

Positive viral test for SARS-COV-2 and symptom onset within the last 7 days: ☐ Yes ☐ No Patient is ≥ 12 years old: ☐ Yes ☐ No

Pediatric patient (12-17 years old): weight ≥ 40 kg: ☐ Yes ☐ No Diagnosis Code (ICD-10):_____U07.1_____

High Risk Criteria for Treatment (select all that apply):

☐ Age ≥ 65 years old ☐ Cardiovascular disease (e.g., heart failure, coronary artery disease, cardiomyopathies, or hypertension) ☐ Cerebrovascular disease ☐ Chronic kidney disease ☐ Chronic lung diseases (e.g., moderate to severe asthma, cystic fibrosis, interstitial lung disease, pulmonary hypertension, bronchiectasis, COPD) ☐ Chronic liver disease ☐ Dementia ☐ Diabetes ☐ Immunosuppressive disease or treatment	☐ Disability (e.g., ADHD, Down syndrome, cerebral palsy, congenital malformations, learning disabilities, spinal cord injuries) ☐ Mental health disorder (mood disorder, including depression, schizophrenia) ☐ Overweight (BMI ≥ 25 kg/m^2) or children age 12-17 with a BMI ≥85th percentile for their age and gender based on CDC growth charts ☐ Physical inactivity ☐ Pregnancy and recent pregnancy ☐ Sickle cell disease or thalassemia ☐ Smoking (current and former) ☐ Substance use disorder ☐ Tuberculosis

I certify no alternative COVID-19 treatment options approved or authorized by the FDA are accessible/clinically appropriate: ☐ Yes ☐ No

I certify that the patient/caregiver has been informed of all the information below: ☐ Yes ☐ No

- ☐ Given the Fact Sheet for Patients, Parents, or Caregivers
- ☐ Informed of alternatives to receiving authorized COVID-19 monoclonal antibody (mAb)
- ☐ Informed it is an unapproved drug authorized for use under Emergency Use Authorization (EUA)
- ☐ Informed that they should continue to self-isolate and use infection control measures (e.g., wear mask, isolate, social distance, avoid sharing personal items) according to CDC guidelines

Consent: Individual spoken with (patient or caregiver's name/relationship): _____

Patient/caregiver was able to ask questions and is agreeable to proceed with the monoclonal antibody: ☐ Yes ☐ No

Medication	Dose	Route	Frequency
Bebtelovimab 175 mg/2 mL over at least 30 seconds per EUA (observe for 1 hour after infusion)		IV	Once
Patient will also have ancillary orders related to the infusion, including instructions and PRN medications for treating infusion related reactions. Medication orders include the following:			
diphenhydrAMINE	50 mg (25 mg for patients > 65 years old)	IV	PRN mild, moderate, severe reaction
EPINEPHrine 1 mg/mL	0.3 mg	IM	

Provider Signature	Printed Provider Name	Date	Time
Provider Contact Number	Provider Address	Provider NPI	

****ALL FIELDS MUST BE COMPLETED FOR THIS ORDER TO BE CONSIDERED VALID****
****FORMS WITH INCOMPLETE DOCUMENTATION WILL NOT BE ACCEPTED****