Beaumont

COVID-19 Monoclonal Antibody Treatment Order

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

Patient Name_____ Date of Birth:_____ MRN:_____

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

Symptom onset and positive viral test for SARS-COV-2 is within the last 7 days: ☐ Yes ☐ No

Diagnosis Code (ICD-10):_____ Patient is ≥ 12 years old and weighs ≥ 40 kg: ☐ Yes ☐ No

Patient is a healthcare worker (including EMS): ☐ Yes ☐ No Is the patient vaccinated?[1] ☐ No ☐ Partially Vaccinated ☐ Fully vaccinated

Select the appropriate Tier below (Criteria based on MDHHS):

Tier (check below)		Eligibility Criteria
☐	1A	• **Age ≥ 75 yo** not up to date with COVID vaccines[1] • **Age ≥ 12 yo**: moderate to severe immunocompromise regardless of vaccine status
☐	1B	• **Age 65 – 74 yo:** not up to date with COVID vaccines[1], and with MI priority risk factor[2] • **Age ≥ 12 yo:** Pregnant and not up to date with COVID vaccines[1]
☐	2	• **Age 65 – 74 yo**: not up to date with COVID vaccines[1] • **Age <65 yo:** not up to date with COVID vaccines[1] with MI priority risk factors[2]
☐	3A	• **Age ≥75 yo**: up to date with COVID vaccines[1] • **Age 65-74 yo**: up to date with COVID vaccines[1], and with MI priority risk factors[2]
☐	3B	• **Age 65-74 yo:** up to date with COVID vaccines[1],and with CDC risk factors
☐	4	• **Age ≥65 yo:** up to date with COVID vaccines[1] • **Age <65 yo**: up to date with COVID vaccines[1], and with CDC risk factors
☐	5	• **Age ≥ 12 yo:** EUA High Risk Criteria (e.g., BMI >25, pregnancy, chronic kidney disease, diabetes, cardiovascular disease, chronic lung disease, immunosuppressive disease or treatment, sickle cell disease, neurodevelopmental disorders, medical-related technological dependence)

[1] Stay Up to Date with Your Vaccines | CDC

[2] MI priority risk factors include: Obesity (BMI ≥ 35), Chronic Respiratory Disease (e.g., COPD, moderate or severe asthma requires daily inhaled corticosteroid, bronchiectasis, CF, ILD), Pregnancy, Chronic Kidney Disease (stage III, IV, or end stage CKD-GFR), Cardiovascular Disease (e.g., HTN, CVA, PAD, CHF), Diabetes

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 antibodies (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
Sotrovimab 500 mg/108 mL over 30 minutes 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 of age)	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****