SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE

CASIVIRIMAB/IMDEVIMAB ORDER FORM
(complete all sections legibly)

Date & Time_________________________ Patient Name_____________________________________

DOB_______________________________ Phone number__________________________________

Allergy: _____________________________ Address: ________________________________________

Name and phone number of nearest relative _______________________________________________

Previously admitted to SMH or JHM: ____Yes     ____No ____Unknown

Casivirimab/Imdevimab is available to only those outpatients who meet both emergency use authorization (EUA) criteria and SMH restrictions. This form should be submitted by the provider via secure email to smh-pharmacist-group@lists.johnshopkins.edu OR faxed to pharmacy department at (202) 537-0072 followed by phone call at (202) 537-4171. Physicians will be notified via phone by the clinical pharmacist within 1 hour for urgent use in the ED or by 1:00 PM each day (for request received by 11:00 AM) whether or not their patient is approved to obtain the treatment in the COVID 19 Infusion Center. Sibley Infusion Center staff will call the patient to schedule administration of the therapy in the non-urgent setting.

Clinical Criteria and Data Requirements for Patient: (Must complete each item as appropriate)

• Confirmed COVID-19 (RNA + respiratory sample) ___Yes    ___No; Date/s of test/s__________________

• ≤10 days of symptom onset: ____Yes     ____No; Date of symptoms onset ____________________________

• List symptoms: ____________________________________________________________________________

• Weight of patient is greater than 40Kg: _____Yes   _____No; if no, note the patient’s weight ____________

• Recent COVID- related hospitalization: _____Yes   _____No; If yes when ____________________________

• Requiring O2 supplementation: _____Yes   _____No; If yes, amount ________________________________

• Received treatment with bamlanivimab: _____Yes   _____No; If yes, when _________________________

• Received or scheduled to receive COVID-19 vaccination _____Yes   ____No; if yes when ______________

• Pregnant: _____Yes   _____No

Patients should meet at least ONE of the following criteria: (please check all that apply)

☐ Have a body mass index (BMI) ≥35
☐ Have chronic kidney disease
☐ Have diabetes mellitus
☐ Have immunosuppressive disease; List ________________________________________________________
☐ Are currently receiving immunosuppressive treatment; List _________________________________________
☐ Are ≥65 years of age
☐ Are ≥55 years of age AND have
  ☐ cardiovascular disease, OR
  ☐ hypertension, OR
  ☐ chronic obstructive pulmonary disease/other chronic respiratory disease

☐ A copy of the Casivirimab/Imdevimab EUA was provided to the patient and the potential adverse effects were discussed. _____Yes   _____No

The prescribing health care provider and/or the provider’s designee are/is responsible for mandatory reporting of all medication errors and serious adverse events potentially related to casivirimab/imdevimab treatment within 7 calendar days from the onset of the event. The reports should include unique identifiers and the words

Revised: 07/2021
SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE

CASIVIRIMAB/IMDEVIMAB ORDER FORM
(complete all sections legibly)

“casivirimab and imdevimab treatment under Emergency Use Authorization (EUA)” in the description section of the report.

Adverse Events/Med Errors: Submit reports to FDA MedWatch online: www.fda.gov/medwatch/report.htm

NURSING ORDERS
☐ Central Venous Access Line, Maintain per VAD Protocol: Routine Until discontinued
☐ Insert Peripheral Saline Lock: Routine Once
☐ Discontinue IV: Routine Once

MEDICATIONS ORDERS
☒ Casivirimab/Imdevimab: 600 mg of casivirimab and 600mg of imdevimab administered together via IV infusion single dose over 60 minutes. Patient should be monitored during infusion and observed for at least 1 hour after infusion is complete.

Anaphylaxis Orders- In case of anaphylactic reaction (sudden decrease in BP, increase in pulse, increased respirations, SOB, and diaphoresis):
☒ General Oxygen: (If condition worsens or progresses to symptoms of anaphylaxis, start O2.): Routine Continuous Delivery Device: ☐ Nasal Cannula ☐ Simple Face Mask ☐ Non-Rebreather Mask ☐ Other _____________
Titrate per Oxygen Titration Protocol- Adult: ☐ Yes ☐ No
☐ Sodium Chloride 0.9%: IV Continuous (100 mL/hr)
☒ EPINEPHrine (ADRENALIN) 1 mg/mL (1:1,000) (1mL) injection: 0.3mg IM every 15 min PRN anaphylactic reaction. Give first. At bedside for RN to give STAT; May repeat third time 5 minutes after 2nd dose, if needed. (3 doses total).
☒ DiphenhydrAMINE (BENADRYL) 50 mg/mL injection: 50 mg, IV Once PRN anaphylactic reaction, For 1 dose. Give after Epinephrine. At bedside for RN to give STAT
☒ Hydrocortisone (Solu-CORTEF) injection: 100 mg IV once PRN anaphylactic reaction. Give after epinephrine and diphenhydramine. At bedside for RN to give STAT.

Hypersensitivity Reactions (skin rash, hives, itching, runny nose, fever)
☒ DiphenhydrAMINE (BENADRYL) capsule/tablet 50mg PO x 1 dose PRN hypersensitivity reaction
☒ Acetaminophen (TYLENOL) 650mg PO x 1 dose. For mild adverse reaction to infusion
☒ Acetaminophen (TYLENOL) oral solution: 650mg PO x 1 dose. Administer only if unable to swallow tablets
☒ Hydrocortisone (Solu-CORTEF) injection: 100mg IV once. For severe hypersensitivity reaction/anaphylaxis reaction.
☒ General Oxygen: (If condition worsens or progresses to symptoms of anaphylaxis, start O2.): Routine Continuous Delivery Device: ☐ Nasal Cannula ☐ Simple Face Mask ☐ Non-Rebreather Mask ☐ Other _____________
Titrate per Oxygen Titration Protocol- Adult: ☐ Yes ☐ No

Other Medication Orders

Revised: 07/2021
CASIVIRIMAB/IMDEVIMAB ORDER FORM
(complete all sections legibly)

___________________________________________________________
__________________________________
__________________________________
M.D (____)___________________________

Signature Cell Number (used for notifying of decisions and questions)

________________________________________
Please Print Name

Note: Only physicians privileged at Sibley Memorial Hospital may prescribe the monoclonal antibodies.

For Pharmacy/Antimicrobial Stewardship Team Use

_________________________________________ RPh Date/Time_____________________

Pharmacy phone number: 202-537-4171

Revised: 07/2021