SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE
BAMLANIVIMAB 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

Bamlanivimab 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; 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 Casivirimab/Imdevimab: ___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 bamlanivimab 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 bamlanivimab treatment within 7 calendar days from the onset of the event. The reports should include unique identifiers and the words “Bamlanivimab 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
SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE
BAMLANIVIMAB ORDER FORM
(complete all sections legibly)

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
☒ Bamlanivimab: 700 mg via IV infusion single dose over 27 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 (1000 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
☒ DiphenhydRAMINE 12.5mg/5mL elixir x 1 dose. Administer only if unable to swallow tablets
☒ 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.
☒ 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
____________________________________________________________________________________________
____________________________________________________________________________________________

Appointment Request
Appointment Request for Bamlanivimab Infusion: ☐ Internal Referral ☐ External Referral
SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE
BAMLANIVIMAB ORDER FORM
(complete all sections legibly)

__________________________________ M.D (____)___________________________
Signature Cell Number (used for notifying of decisions and questions)

_________________________________
Please Print Name

For Pharmacy/Antimicrobial Stewardship Team Use

_______________________________ RPh Date/Time_______________

Pharmacy phone number: 202-537-4171