

San Antonio Regional Infusion Center (SA-RIC)

Patient Screening/Referral & Order Set Form

Today's Date: _____

Referring Physician Information

Physician Name: _____ NPI #: _____
Office Name: _____ Physician Phone: _____
Physician Email: _____ Physician Fax: _____

Patient Information







Patient Name: _____ DOB: _____ Age: _____
Cell Phone: _____ Email: _____
Transportation/Contact Name: _____ Cell Phone: _____
Emergency Contact Name: _____ Cell Phone: _____

Date of Onset of Illness (Mild to Moderate*) _____ = _____ Day of Illness (<10)

Check all symptoms that are present:

- | | | | |
|--------------------------------------|--------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Malaise | <input type="checkbox"/> Nausea | <input type="checkbox"/> Loss of taste/smell |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Headache | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dyspnea on exertion |

Date of Testing for COVID: _____ Test Type: PCR Antigen No Test

- Symptoms present less than 10 days: Yes No /  : Not Eligible
- spO₂% >94% on RA: Yes No /  : Not Eligible
- Patient is still not vaccinated for COVID-19 Yes No /  : Not Eligible Date of Vaccine: _____
- If previously on home O₂, has no increased need: Yes No /  : Not Eligible N/A
- Stable for discharge home: Yes No /  : Not Eligible
- Documented positive COVID test performed : Yes No /  : Not Eligible

*NIH Definition:

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhea, loss of taste and smell) but who do not have shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who show evidence of lower respiratory disease during clinical assessment or imaging and who have saturation of oxygen (SpO₂) ≥94% on room air at sea level.

High Risk Patients Eligible for Care Who Meet One of the Following Criteria

Check below for each that meets the Monoclonal Antibody Infusion inclusion criteria:

- | | |
|--|---|
| <input type="checkbox"/> Is ≥65 years of age | <input type="checkbox"/> Is currently receiving immunosuppressive treatment |
| <input type="checkbox"/> Has a body mass index (BMI) ≥35 | <input type="checkbox"/> Are ≥55 years of age AND have: |
| <input type="checkbox"/> Has chronic kidney disease | <input type="checkbox"/> Cardiovascular disease, OR |
| <input type="checkbox"/> Has diabetes | <input type="checkbox"/> Hypertension, OR |
| <input type="checkbox"/> Has immunosuppressive disease | <input type="checkbox"/> Chronic obstructive pulmonary disease/other chronic respiratory disease. |

Appointment to infuse scheduled: _____ at _____ (before 10th day since symptom onset)

Provide Patient mAB Instruction Sheet, directions for infusion center and discharge

Email completed form to _____ Refer@strac.org _____ or fax to _____ 210-208-5295

Monoclonal Antibody Infusion: Regeneron or Bamlanivimab Order Set

Eligibility Requirements

- Patient is not asymptomatic and has mild to moderate illness as noted by all of the following criteria:
- Is not hospitalized due to COVID-19, OR
 - Does not require oxygen therapy due to COVID-19 and has a saturation of oxygen (SpO₂) ≥94% on room air at sea level, OR
- Patient is not:
- Day 10 or greater since symptom onset
 - If pregnant, not cleared with OB/GYN Physician
 - Received COVID-19 vaccine in the past 90 days

Infusion Instructions for Available Monoclonal Antibody

IMPORTANT NOTE:

Both Regeneron and Bamlanivimab options must be checked to avoid inability to infuse your patient due to indeterminate monoclonal antibody supply.

- If Regeneron is the available monoclonal antibody available**, withdraw 10 mL of Casirivimab and 10 mL of Imdevimab from each respective vial using two separate syringes and dilute together in a 250 mL 0.9% NS (total volume 270mL) if not premixed. Infuse thru an in-line or add-on 0.20/0.22 micron polyethersulfone (PES) filter tubing over 60 minutes. Flush the infusion line to ensure delivery of the required dose at conclusion.
- If Bamlanivimab is the available monoclonal antibody available**, infuse 700 mg of Bamlanivimab mixed as 1 vial 700 mg Bamlanivimab/20 mL in 250 mL 0.9% NS (total volume 270 mL) thru an in-line or add-on 0.20/0.22 micron polyethersulfone (PES) filter tubing over 60 minutes. Flush the infusion line to ensure delivery of the required dose at conclusion.
- Monitor patients' vitals every 30 minutes after infusion for any adverse response (hypotension SBP <90, tachycardia (HR >100) or fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, dizziness.
- Stop infusion for any adverse response
- Notify MD any adverse response
- Call 911 any severe adverse response (Hypotension, bronchospasm, angioedema, severe bronchospasm)

1 Hour Post Infusion Completion

- Monitor patients' vitals every 30 minutes after infusion for any adverse response (hypotension SBP <90, tachycardia (HR >100) or fever, chills, nausea, headache, bronchospasm, hypotension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, dizziness.
- Notify MD any adverse response
- Call 911 any severe adverse response (Hypotension, angioedema, anaphylaxis, severe bronchospasm)
- Remove IV and discontinue infusion if no adverse response at end of infusion.

As Needed Orders

Serious Adverse Events include: Angioedema, Anaphylaxis, Hypotension, or any Issue requiring EMS Transport by 911

- Nausea If patient develops nausea, administer Zofran 4 mg IV x 1. May repeat in 1 hour if not improved
- Headache If patient develops headache, administer 650 mg of Acetaminophen if not allergic
- Hives
 - Administer Benadryl 12.5 mg IV. May repeat in 30 minutes if not improved.
- Itching
 - Administer Solumedrol 1 mg/kg IV
- Bronchospasm
 - Discontinue infusion
 - Apply monitor, Call 911 if severe
- Angioedema
 - Administer Benadryl 12.5 mg IV. May repeat in 30 minutes if not improved.
 - Administer Solumedrol 1 mg/kg IV
 - Discontinue infusion
 - Apply monitor, Call 911
- Hypotension (SBP <90) If patient develops hypotension, stop product and administer 1000 mL NS, discontinue infusion.
 - Apply monitor, call 911.
- Anaphylaxis
 - Anaphylaxis must involve at least 2 body systems (Hypotension AND Hives as an example)
 - Epinephrine 1:1000: 0.01 mg/kg IM; max dose 0.3 mg (0.3 mL) IM or EpiPen. May repeat every 5 min up to 3 doses.
 - Discontinue infusion
 - Apply monitor, call 911
 - Administer Benadryl 12.5 mg IV. May repeat in 15 minutes if not improved and EMS not arrived.
 - Administer Solumedrol 1 mg/kg IV

ADDENDUM to Monoclonal Antibody Infusion Care

- The following may be substituted when the IV form is not available:
 - Prednisone 20 mg tab 2 po once for Solumedrol 1 mg/kg IV or Dexamethasone 4 mg IV
 - Zofran 4 mg tab 1 po for Zofran 4 mg IV
 - Benadryl 25 mg 1 tab po for Benadryl 12.5 mg IV
- The following IV to IV may be substituted when the same drug is not available
 - Dexamethasone 4 mg IV for Solumedrol 1 mg/kg IV
- Generics may be substituted for name brand for any rescue medication listed (example, ondansetron for Zofran)
- Give patient the monoclonal antibody information which they were assigned for treatment
- Give patient the COVID-19 Care Guide for home care

Physician Name: _____

Date: _____

Physician Signature: _____