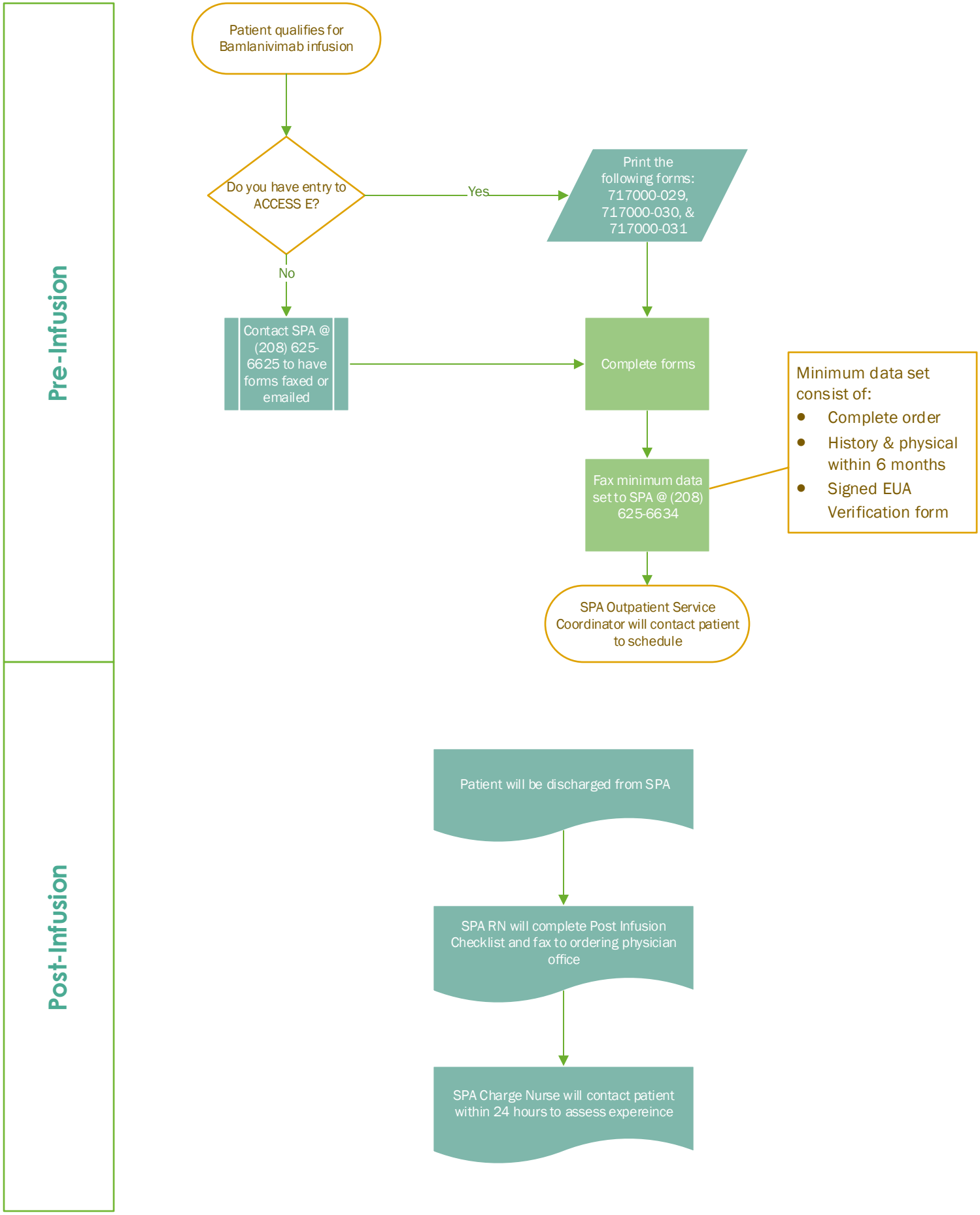
Bamlanivimab Infusion Process



All highlighted areas must be completed before the patient will be scheduled.

BAMLANIVIMAB ORDER SET

Completion by Physician's Office

Full Name of Patient: _____ DOB: _____

Address: _____ City: _____ Zip: _____

_____

_____

Weight: _____kg Height: _____cm

BAMLANIVIMAB CONTRAINDICATIONS: hypersensitivity to any ingredient, hospitalization, increased or new O2 requirement due to COVID-19

Diagnosis: COVID-19

Visit Frequency: **Once**
Dosage: 700 mg IV in 200 ML normal saline over 60 minutes once within 10 days of onset symptoms.

Bamlanivimab Infusion:

- Administer using 0.22 micron (or smaller) non protein binding in-line filter in PVC line
- Do not infuse other medication into the IV line with Bamlanivimab.
- For mild reaction slow the infusion to see if symptoms resolve
- Common reactions include N/V/D dizziness, H/A, pruritus For severe reaction, SOB, hypotension, bronchospasm, etc.
- **CALL PHYSICIAN and Rapid Response Team**

EUA REQUIREMENTS

PLEASE IDENTIFY PATIENT'S HIGH RISK CRITERIA (MUST MEET ONE):

- ❑ Greater than or equal to 65 years old
- ❑ Age 18 and up with Body mass index (BMI > or equal to 35)
- ❑ Age 18 and up with Chronic kidney disease
- ❑ Age 18 and up with Diabetes
- ❑ Age 18 and up with Currently immunosuppressed or receiving immunosuppressive therapy
- ❑ Age 55 and up with cardiovascular disease
- ❑ Age 55 and up with hypertension
- ❑ Age 55 and up with chronic respiratory or lung disease

HCP's are required to submit a report on all medication errors and all serious adverse events to FDA medwatch. Submitted reports should include in the field name "Describe Event, Problem, or Product use/Medication Error" the statement " Bamlanivimab treatment under Emergency Use Authorization (EUA)"

Bamlanivimab Infusion Procedure:

- Start Saline Lock / May use Lidocaine 1% intradermally

Pre-meds (give 30 min prior to start of infusion):

- ❑ No pre-meds
- ❑ Acetaminophen (Tylenol) 650 mg po x 1
- ❑ Loratidine (Claritin)10 mg PO x 1
- ❑ Famotidine (Pepcid) 20 mg PO x 1

During Infusion:

- ☑ Vital Signs and O2 sats every 15 minutes x 2, then if stable every 30 minutes until infusion complete.

After Infusion

Observe patient for 60 minutes post infusion for infusion reaction. If stable, may discontinue IV and dismiss patient.

For Adverse Reaction (Emergency Orders):

- Acetaminophen (Tylenol) 650 mg po x1 for temperature more than 37.8 degrees C or headache
- Diphenhydramine (Benadryl) 25 mg IV x 1 prn pruritis, SOB, or hives.
- Methylprednisolone (Solumedrol) 125 mg IV x 1 prn pruritis, SOB, or hives
- Call Rapid Response Team for sever reaction
- Oxygen by Nasal Cannula at 2.5 liters/min, if needed for chest pain or dyspnea.
- Call Physician

Diagnosis:

- ☑ U07.1 COVID-19 infection
- ❑ J40 bronchitis NOS
- ❑ J12.89 other viral pneumonia
- ❑ J20.8 acute bronchitis due to other specified organisms
- ❑ J22 unspecified acute lower respiratory infection
- ❑ J98.8 other specified respiratory disorders

Diagnosis placing patient at high-risk for severe COVID-19 illness-Include ICD-10 code(s)description(s)

Prescriber must indicate *all* of the following requirements have been met:

- ❑ Patient/caregiver has been given the Fact Sheet for Patients and Parents/Caregivers
- ❑ Patient/caregiver has been informed of alternatives to receiving bamlanivimab
- ❑ Patient/caregiver has been informed that bamlanivimab is an unapproved drug that is authorized for use under an Emergency Use Authorization.

Physician Signature: _____ Date: _____ Time: _____

All highlighted areas must be completed before the patient will be scheduled.

Bamlanivimab Emergency Use Authorization (EUA) Verification Form

I, _____ (patient or legal guardian please print) verify that the following information has been reviewed with me prior to receiving bamlanivimab infusion per the provisions of the Emergency Use Authorization of bamlanivimab issued by the Food and Drug Administration (FDA) for use in _____ (Patient please print)

❑ I confirm that I do not have any of the following contraindications

- Any known hypersensitivity to any ingredient of the Bamlanivimab
- Are currently hospitalized due to COVID−19
- Require oxygen therapy due to COVID−19
- Require an increase in baseline oxygen flow rate due to COVID−19 in those on chronic oxygen therapy due to underlying non−COVID−19 related comorbidity

❑ I have been given the Fact Sheet for Patients, Parents, and Caregivers (Appendix I of the bamlanivimab policy)

❑ I have been informed of alternatives to receiving bamlanivimab

❑ I have been informed that bamlanivimab is an unapproved drug that is authorized for use under this EUA

_____ _____

Patient / Legal Guardian Date