Sotrovimab Order Set
For Adults and Pediatric Patients (12 years of age and older, weighing at least 40 kg)

Completion by Prescriber's Office Weight:_____kg Height: _____cm

Full Name of Patient _____ DOB: _____

Address:_____ City:_____ Zip: _____

Patient Allergies: _____

- Please see Emergency Use Authorization and Full Fact Sheet for Healthcare Providers for full prescribing information before ordering Sotrovimab

CONTRAINDICATIONS:hypersensitivity to any ingredients, hospitalization, increased or new O2 requirements due to COVID−19

Diagnosis: Mild to moderate COVID−19 in adults and pediatrics (12 years of age and older weighing at least 40 KG) with positive results of SARS−CoV−2 and who are at high risk of progression to severe COVID−19

Visit Frequency: Once within 10 days of symptom onset

Dosage:500 mg given as single IV infusion over 30 minutes and must be within 10 days of onset of symptoms

Sotrovimab Infusion: Sotrovimab is a concentrated solution and must be diluted prior to infusion. Using PVC or PO sterile prefilled 50−mL or 100−mL normal saline 0.9% or dextrose 5% infusion bags. Allow vial of Sotrovimab vial 500 mg/8mL to equilibrate to room temperature before injecting into infusion bag
Administer using 0.2 micron (PES) filter is recommended, administer the entire infusion bag over 30 minutes including possible overfill to avoid under dosage
Do not administer simultaneously with any other medication
Once complete flush tubing with 0.9% saline or 5% dextrose
Clinically monitor for at least 1 hour after infusion is complete

EUA REQUIREMENTS
PLEASE IDENTIFY PATIENT'S QUALIFYING CRITERIA:

- ❑ Patient is NOT currently hospitalized due to COVID−19
- ❑ Patient does NOT require oxygen therapy due to CoVID−19
- ❑ OR who 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)
- ❑ Pregnancy
- ❑ Older age (for example =65 years of age)
- ❑ Obesity or being over weight
- ❑ Chronic Kidney disease
- ❑ Diabetes
- ❑ Immunosuppressive disease or immunosuppressive treatment
- ❑ Cardiovascular disease (including congenital heart disease) or hypertension
- ❑ Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate−to−severe], interstitial lung disease, cystic fibrosis, and pulmonary hypertension)

Pre−Meds:

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

Post−Infusion:

Flush tubing with 0.9% saline or 5% dextrose (based on infusion bag contents) Clinically monitor patient after infusion for at least 1 hour. If stable, discontinue IV and dismiss patient.

For Adverse Reaction (Emergency Orders):

- ❑ Zofran 4 mg ODT or IV x1 prn nausea/vomiting
- ❑ Epinephrine 0.3mg Kit IM x1 prn anaphylaxis
- ❑ Diphenhydramine (Benadryl) 25 mg IV x 1 prn pruritis, SOB, or hives.
- ❑ Methylprednisolone (Solumedrol) 125 mg IV x 1 prn pruritis, SOB, or hives
- ❑ Oxygen by Nasal Cannula at 2.5 liters/min, if needed for chest pain or dyspnea.
  - Call Physician
  - Call Rapid Response Team for severe reaction at KIS

❑ Sickle cell disease ❑ Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies) ❑ Having a medical−related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation [not related to COVID 19]) Other medical conditions or factors: _____ _____	

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 Sotrovimab
- ❑ Patient/caregiver has been informed that Sotrovimab is an unapproved drug that is authorized for use under an Emergency Use Authorization.

Prescriber Signature: _____ Date: _____ Time: _____

Prescriber Printed Name: _____