Cascade ID & Infusion

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐M ☐F Weight: _____ lbs.	NPI:_____
Height:_____ICD-10 Code(s):_____	Practice:_____
Diagnosis: _____	Phone:_____
Allergies: _____	Fax:_____
Primary Care Provider:_____	Contact Name:_____

☐ Monoclonal Antibody Treatment

- **Sotrovimab** 500 mg IV x 1 dose
- **Casirivimab** 600 mg IV & **Imdevimab** 600 mg x 1 dose
- **Bamlanivimab** 700 mg IV & **Estesevimab** 1,400 mg x 1 dose

mAb will be selected based on availability.

PRN-Medication(s):

☐ Acetaminophen/Tylenol: 650 mg PO

☐ Diphenhydramine/Benadryl: 25 mg IV

☐ Ondansetron/Zofran: 4 mg IVP

*****Patients are only eligible to receive infusion within 10 days of symptom onset.*****

Quick Checklist for mAb patients.

☐ I have discussed the EUA requirements and reviewed the fact sheet for the patients, parents or caregiver.

☐ I have informed the patient that they should not receive a COVID vaccine for at least 90 days following the mAb infusion.

☐ The patient has has given verbal consent to receive the mAb infusion.

☐ Include demographic sheet and if applicable a copy of the insurance card(s).

☐ Completed Cascade ID & Infusion Specialty Order Form.

☐ Positive COVID laboratory report. (date of report if it is unavailable: _____)

☐ Recent progress note including the onset of symptoms date. (date of onset if note is unavailable: _____)

Physician's Signature:_____ **Date:**_____