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:_____

☐ **Bamlanivimab** 700 mg IV & **Estesevimab** 1,400 mg IV x 1 dose

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.

☐ I have reviewed travel and contact history within 2 weeks prior to infection or exposure to SARS-CoV-2.

(Persons who have traveled to, resided in, or had close contact with an infected individual from the state of Hawaii where the frequency of resistant variants to bamlanivimab and etesevimab exceeds 5% should not receive bamlanivimab and etesevimab. Other monoclonal antibody therapy options should be considered.)

☐ 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.

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

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

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