

REGEN-COV™ (CASIRIVIMAB-IMDEVIMAB) PRESCRIBER ORDER FORM

Patient Name:

Date of Birth:

Gender:

Address:

Phone:

Height:

 inches cm

Weight:

 lbs kg**Clinical Information**

Primary Diagnosis Description:

ICD-10 Code:

REGEN-COV™ (Casirivimab-Imdevimab) Prescription**COVID-19 Treatment**

Date of First Symptom Onset: _____

Date of Positive COVID-19 Test: _____

- Administer casirivimab 600 mg | imdevimab 600 mg one time only ASAP after a positive COVID-19 test and within 10 days of symptom onset.

Method of Administration: Infuse by IV via gravity infusion over 20 to 50 minutes. Inject subcutaneously.

COVID-19 Post-Exposure Prophylaxis

Suspected Date of Exposure: _____

- Initial:** Administer casirivimab 600 mg | imdevimab 600 mg one time only ASAP after exposure to COVID-19.
- Ongoing:** Administer casirivimab 300 mg | imdevimab 300 mg every 4 weeks starting 4 weeks after initial prophylactic dose for the duration of exposure. **Stop Date for Ongoing Prophylaxis Dosing:** _____

Method of Administration: Infuse by IV via gravity infusion over 20 to 50 minutes. Inject subcutaneously.

For IV infusions, flush IV tubing with 0.9% Sodium Chloride 25 to 50 mL after infusion to ensure delivery of required dose. If nurse is unable to establish peripheral IV access for infusion, ordered dose will be administered subcutaneously.

Ancillary Orders**Anaphylaxis Kit**

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

IV Access Device and Flush Orders

- Peripheral:** 0.9% Sodium Chloride 2 to 3 mL pre-/post-infusion.

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, patient meets at least one of the inclusion criteria, patient does not meet any of the exclusion criteria, and that I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:

Phone:

Fax:

Address:

NPI:

City, State:

Zip:

Office Contact:

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