

Shenandoah Memorial Hospital

Monoclonal Antibodies for COVID 19

EMAIL orders to smhrph@valleyhealthlink.com (SMH only)

ALLERGIES				
Weight in Kilograms Height				
DIAGNOSIS: COVID-19 STATUS: OUTPATIENT HCPCS Codes: Q0222 (drug), M0222 (admin)				
Emergency Use Authorization				
For non-hospitalized patients, not on oxygen or without an increase in home oxygen flow rate				
FORM MUST BE COMPLETED IN ENTIRETY OR ORDER WILL BE REJECTED				
1. POSITIVE SARS-CoV-2 test: VES NO DATE:				
2. DATE OF SYMPTOM ONSET (Must be within 7 days):				
3. ***REASON for NOT prescribing 1st line drug nirmatrelvir/ritonavir (Paxlovid):				
□ ABSOLUTE drug interaction contraindication List drug(s):				
□ eGFR less than 30 ml/min (Including dialysis patients)				
4. Vaccination Status: □ 2-Dose Pfizer or Moderna □ J&J □ Booster/3 ^{rd/} 4 th dose □ Unvaccinated				
5. Code Status: □ Full Code or □ No CPR – Support OK □ No CPR – Allow Natural Death				
6. High Risk Criteria (Please check all that apply):				
□ Body mass index (BMI) greater or equal to 30 BMI:				
Chronic kidney disease, stages 3 to 5				
 Currently receiving immunosuppressant treatment – chemotherapy, immunotherapy, prednisone 20 mg daily or equivalent, OR have chronic immunosuppressive disease 				
□ Age 65 years or greater				
 Cardiovascular disease or hypertension 				
Chronic lung disease				
□ Sickle cell disease				
 Neuro-developmental disorders (ex. Cerebral palsy) 				
Pregnancy: Weeks:				
Date: Time: Physician Phone Number:				
Physician Signature:				
Physician Name (Print):				

ValleyHealth

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DIAGNOSIS: CO		STATUS:	OUTPATIENT	
Pharmacy may a	auto-substitute the antib	odv medication/route ba	sed on availability or variants	
		over 30 seconds using a s	-	
Monit of the angioe	or the patient for any sign following occur: Fever, ch edema, throat irritation, ras	ills, nausea, headache, bro sh including urticaria, prurit	tion . Stop the injection/infusion if an onchospasm, hypotension, tus, myalgia, or dizziness	
• Monit	or the patient for one hou	Ir after the end of the injec	tion/infusion	
For allergic/ana	phylactic reactions			
 Stop the inject 	tion/infusion and notify the	e MERT team		
	pinephrine 0.3 mg (1mg/ml) IM x 1 dose as needed for anaphylaxis (see above anaphylactic reaction signs)			
		or PO X 1 dose for itching,		
Famotidine (F	Pepcid) 40 mg IV x 1 dose	for itching, swelling, or ras	sh	
Methylprednis	solone (Solu-Medrol) 125 i	mg IV x 1 dose for itching,	swelling, or rash	
Albuterol sulfa	ate (Proventil) 2 puffs inha	led every 10 minutes up to	3 doses for wheezing, bronchospas	
 If a reaction of 	occurs, document in EPIC,	complete risk report, and	notify pharmacy	
7. 🗆 Copy of In	surance Card (front and	back) attached in case p	prior authorization required	
Provider to Com	plete:			
8. 🛛 Risks and	benefits discussed with pa	tient and obtain informed	consent	
9. De Patient Info	ormation Sheet provided to	patient/caregiver		
Date:	Time:	Physician Phor	ne Number:	
Physician Signa	ture:			
Physician Name	(Print):			