Community Provider Order for Regeneron Infusion

Orders from noncredentialled community providers will be reviewed by the Orlando Infusion Annex Medical Director

This authorization only permits casirivimab-imdevimab to be used to treat:

- Adults & pediatric patients (age ≥12 and weight ≥40 kg)
- Date Positive _____ SARS-CoV-2 viral testing High risk* for progressing to severe COVID-19 and/or hospitalization.
- Date of COVID-19 symptom onset: _____

***High risk (at least one of the following criteria):**

- BMI ≥35 • CKD • Diabetes • Immunosuppressive disease
- Receiving immunosuppressive treatment
- Age ≥65 years
- Age ≥55 years **AND** one of the following:
  - ○ Cardiovascular disease
  - ○ Hypertension
  - ○ COPD/other chronic respiratory disease

Age 12-17 AND one of the following:

o BMI ≥ 85th percentile
o Sickle cell disease
o Neurodevelopmental disorders (i.e. cerebral palsy)
o Congenital or acquired heart disease
o Medical-related technological dependence (i.e., tracheostomy gastrostomy, or positive pressure ventilation)
o Asthma, reactive airway or other chronic respiratory disease that requires daily medication

Not authorized for: • Patients who are hospitalized due to COVID-19 • Patients who require oxygen therapy due to COVID-19 • Patients who require an increase in baseline oxygen flow rate due to COVID-19 • Prevention of COVID-19 Patients with known hypersensitivity to any ingredient Casirivimab-imdevimab must not receive Casirivimab-imdevimab

ADT Status/Condition

☑ Outpatient Services: AdventHealth Infusion

Medications

☑ Casirivimab-imdevimab 1200 mg ea IV Once

Notifications/Instructions

☑ I have confirmed that the patient meets FDA EUA criteria for use
☑ I have informed the patient of alternative to receiving authorized Casirivimab-imdevimab
☑ I have informed the patient that Casirivimab-imdevimab is an unapproved drug authorized for use under EUA
☑ Risk and benefits of the therapy were discussed, and all questions were answered.
☑ The Casirivimab-imdevimab fact sheet has been reviewed and given to the patient

DC Orders

☑ Refer to Remote Patient Monitoring (RPM)
☑ Refer to Home Physician's Group for RPM escalation

Fax Orders to 1-407-303-0534, include copy of patient insurance card front/back

Patient Allergies: _____

Physician Print/Sign or STAMP Name: _____ NPI# _____Date/Time: _____

Provider Phone Number: _____Medical Director Review/Signature: _____

Title: Community Provider Casirivimab-imdevimab
Infusion Order **(2/24/21) – POD Page 1 of 1**

AdventHealth Orlando

PT Name: _____

DOB: _____ Patient Label

Phone Number: _____