SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE

BEBTELOVIMAB ORDER FORM FOR TREATMENT

(complete all sections legibly)

Date &Time_____ Patient Name_____

DOB_____ Phone number _____

Allergy: _____ Address: _____

Name and phone number of nearest relative _____

Previously admitted to SMH or JHM: ____Yes ____No ____Unknown

Bebtelovimab is available to patients who meet emergency use authorization (EUA) criteria. **This form should be submitted by the provider via secure email to smh-pharmacist-group@lists.johnshopkins.edu OR fax to pharmacy department at (202) 537-0072 followed by phone call at (202) 537-4171.** Physicians will be notified via phone by the clinical pharmacist within 1 hour for urgent use in the ED or by 1:00 PM each day (for request received by 11:00 AM) whether or not their patient is approved to obtain the treatment managed via the Infusion Center. Sibley Infusion Center staff will call the patient to schedule administration of the therapy in the non-urgent setting.

Clinical Criteria and Data Requirements for Patient: (Must complete each item as appropriate)

- Confirmed COVID-19 (RNA + respiratory sample) ___Yes ___No; Date/s of test/s_____
- ≤7 days of symptom onset: ____Yes ____No; Date of symptom onset _____
- List symptoms: _____
- Weight of patient is ≥ 40Kg : ____ Yes ____ No; if no, note the patient's weight _____
- Age ≥ 12 years of age: _____ Yes _____ No
- Recent COVID- related hospitalization: ____ Yes ____No; If yes when _____
- Requiring O2 supplementation: _____ Yes _____No; If yes, amount _____
- Received or scheduled to receive COVID-19 vaccination _____ Yes ____No; if yes, when _____
- Risk factors as defined below (please list risk factors): _____
- I confirm Bebtelovimab is NOT authorized for use in patient: _____ Yes ____ No
  - who are hospitalized due to COVID-19, OR
  - who require oxygen therapy due to COVID-19, OR
  - who require an increase in baseline oxygen flow rate due to COVID-19 (in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity)
  - Children ≤12 years old

SYMPTOMATIC patients who DID NOT RECEIVE nirmatrelvir and ritonavir (Paxlovid)

GROUP 1

Patients should meet at least **ONE** of the following criteria: (please check all that apply)

- ☐ Immunosuppressive B-Cell Disorder or active hematologic malignancy (with or without BMT)
- ☐ Solid organ transplant
- ☐ Known vaccine non-responder (Seronegative on anti-spike/RBD assay)
- ☐ Pregnant or ≤ 6 weeks post-partum

OR

GROUP 2A (unvaccinated)

Symptoms ≤ 6 days and patients should meet at least **ONE** of the following criteria: (please check all that apply)

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☐ Age ≥ 80

☐ Age ≥ 65 AND ≥ 2 Risk Factors as defined below (please list risk factors):

_____

Note: The EUA defines high risk as: ≥65 years of age; BMI >25 kg/m^2, pregnancy; chronic kidney disease (eGFR < 60mL/min); diabetes; immunosuppressive disease or currently receiving immunosuppressive treatment; cardiovascular disease (including congenital heart disease) or hypertension; chronic lung diseases (e.g., chronic obstructive pulmonary disease, asthma [moderate to severe], interstitial lung disease, cystic fibrosis), and pulmonary hypertension; sickle cell disease; neurodevelopmental disorders (e.g., cerebral palsy), or other conditions that confer medical complexity (e.g., genetic or metabolic syndromes and severe congenital anomalies); having a medical-related technological dependence (eg, tracheostomy, gastrostomy, positive pressure ventilation [not related to COVID-19]).

☐ A copy of the Bebtelovimab EUA was provided to the patient and the potential adverse effects were discussed.
_____ Yes ____No; if no list reason_____

The prescribing health care provider and/or the provider's designee are/is responsible for mandatory reporting of all medication errors and serious adverse events potentially related to Bebtelovimab treatment within 7 calendar days from the onset of the event. The reports should include unique identifiers and the words "Bebtelovimab treatment under Emergency Use Authorization (EUA)" in the description section of the report.

Adverse Events/Med Errors: Submit reports via HERO and to FDA MedWatch online: www.fda.gov/medwatch/report.htm

NURSING ORDERS

☐Central Venous Access Line, Maintain per VAD Protocol: Routine Until discontinued

☐ Insert Peripheral Saline Lock: Routine Once

☐ Discontinue IV: Routine Once

MEDICATIONS ORDERS

☒ Bebtelovimab: 175mg administered via IV injection over at least 30 seconds.
Patient should be monitored during injection and observed for at least 1 hour after administration.

Anaphylaxis Orders- In case of anaphylactic reaction (sudden decrease in BP, increase in pulse, increased respirations, SOB, and diaphoresis):

☒ General Oxygen: (If condition worsens or progresses to symptoms of anaphylaxis, start O2.): Routine Continuous

Delivery Device: ☐ Nasal Cannula ☐ Simple Face Mask ☐ Non-Rebreather Mask ☐ Other _____

Titrate per Oxygen Titration Protocol- Adult: ☐ Yes ☐ No

☒ Sodium Chloride 0.9%: IV Continuous (100 mL/hr)

☒ EPINEPHrine (ADRENALIN) 1 mg/mL (1:1,000) (1mL) injection: 0.3mg IM every 15 min PRN anaphylactic reaction. Give first. At bedside for RN to give STAT; May repeat third time 5 minutes after 2nd dose, if needed. (3 doses total).

☒ DiphenhydrAMINE (BENADRYL) 50 mg/mL injection: 50 mg, IV Once PRN anaphylactic reaction, For 1 dose. Give after Epinephrine. At bedside for RN to give STAT

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☒ Hydrocortisone (Solu-CORTEF) injection: 100 mg IV once PRN anaphylactic reaction. Give after epinephrine and diphenhydramine. At bedside for RN to give STAT.

Hypersensitivity Reactions (skin rash, hives, itching, runny nose, fever)

☒ DiphenhydrAMINE (BENADRYL) capsule/tablet 50mg PO x 1 dose PRN hypersensitivity reaction

☒ DiphenydrAMINE 12.5mg/5mL elixir- 50mg x 1 dose. Administer only if unable to swallow tablets

☒ Acetaminophen (TYLENOL) 650mg PO x 1 dose. For mild adverse reaction to infusion

☒ Acetaminophen (TYLENOL) oral solution: 650mg PO x 1 dose. Administer only if unable to swallow tablets

☒ Hydrocortisone (Solu-CORTEF) injection: 100mg IV once. For severe hypersensitivity reaction/anaphylaxis reaction.

☒ General Oxygen: (If condition worsens or progresses to symptoms of anaphylaxis, start O2.): Routine Continuous

Delivery Device: ☐ Nasal Cannula ☐ Simple Face Mask ☐ Non-Rebreather Mask ☐ Other _____

Titrate per Oxygen Titration Protocol- Adult: ☐ Yes ☐ No

Other Medication Orders

_____

_____

_____M.D (____)_____

Signature Cell Number (used for notifying of decisions and questions)

_____

Please Print Name

Note: Only physicians privileged at Sibley Memorial Hospital may prescribe the monoclonal antibodies.

For Pharmacy/Antimicrobial Stewardship Team Use

_____ RPh Date/Time_____

Pharmacy phone number: 202-537-4171