**Example: Home Infusion Provider Bamlanivimab Order Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of First Symptom Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COVID Positive Result Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Patient Eligibility***

Exclusion Criteria (Patients meeting any of the following criteria are NOT ELIGIBLE for bamlanivimab therapy)

* 1. who are hospitalized due to COVID-19
  2. who require oxygen therapy due to COVID-19
  3. 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

***By signing this order, physician verifies that none of the above criteria apply.***

**Inclusion Criteria**: (at least one of the following criteria must be met to qualify for bamlanivimab therapy)

**Check all that apply (replace letters with check boxes):**

Patient is 12 years of age or older weighting at least 40 kg

Patient Weight: \_\_\_\_\_\_\_\_\_\_\_ kg Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients must have at least one of the following (select all that apply):

 Body Mass Index greater to or equal to 35

 Chronic Kidney Disease

 Diabetes

 Immunosuppressive Disease (i.e. CVID)

 Currently receiving immunosuppressive treatment

 ≥ 65 years of age

 ≥ 55 years of age, AND have at least one of the following: Cardiovascular disease, Hypertension, COPD or other respiratory disease

 Ages 12-17 AND have at least one of the following:

 BMI ≥ 85th percentile for the age & gender based on the CDC growth charts (<https://www.cdc.gov/growthcharts/clinical_charts.htm>)

 Sickle Cell Disease

 Congenital or Acquired heart disease

 Neurodevelopmental disorders

 Medical-related technological dependence (i.e. tracheostomy, gastrostomy, ventilator (not related to COVID-19)

 Asthma, Reactive airway, or other chronic respiratory disease requiring daily medication

***Home Infusion Orders:***

Bamlanivimab ***700mg/270 ml*** 0.9% Sodium Chloride to be infused via gravity or infusion pump over 60 minutes x 1 dose

(Must use a 0.2 or 0.22 micron filter for administration)

 50ml 0.9% Sodium Chloride

Once infusion is complete, flush the infusion line with 50ml 0.9% Sodium Chloride to ensure delivery of required dose.

Anaphylaxis Kit if not available at infusion location

***(Insert your organizational protocol here)***

***Vascular Access Device (VAD) Orders:***

Flush Protocol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

0.9% NS: \_\_\_\_ml Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heparin \_\_u/ml; \_\_\_ml Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Peripheral Vascular Access Device: Skilled nursing to assess and insert peripheral access device for administration of bamalanivimab.

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Services:**

**Pharmacy Services:** Assessment of patient eligibility, administration method, education on medication side effects, interactions, adverse reactions, and infusion-related reactions.

**Nursing Services**: Skilled nursing to administer bamlanivimab, patient assessment, and monitoring.

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_