BEACON HEALTH SYSTEM

Bremen Hospital Outpatient Remdesivir / Bebtelovimab Order Form for Adult COVID + Patients

Bebtelovimab is only indicated for use when Paxlovid or Remdesivir are not available, feasible to use, or clinically appropriate

Patient Name: _____ **Patient DOB:** _____ **Patient Phone**:_____

Patient Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Patient Gender: _____ **Patient Weight (kg):**_____ **Patient Height (in):**_____ **Pregnant**: ☐ Yes ☐ No

Primary Insurance: _____

Plan Number:_____ **Policy Holder Name**:_____

Secondary Insurance: _____

Plan Number:_____ **Policy Holder Name**: _____

Accessibility: ☐ Patient is ambulatory ☐ Requires wheelchair ☐ Requires stretcher **Preferred Language**:_____

Patient Allergies: _____ **Patient Diagnosis:** COVID-19

Date of COVID-19 positive test: _____ **Date of Symptom Onset:** _____

Last date eligible for infusion (7 days from symptom onset): _____

Outpatient Remdesivir Criteria & Monoclonal Antibody Emergency Use Authorization (EUA):

The criteria below are for the FDA approved use of Remdesivir or the emergency use authorization of Bebtelovimab for the treatment of mild to moderate COVID-19 in adult and select pediatric patients with positive results of direct SARS-CoV-2 viral testing who are at high risk for progressing to severe COVID-19 and/or hospitalization.

High risk is defined as patients who meet at least one of the following criteria (check the qualifying condition for this patient):

- ☐ ≥65 years of age
- ☐ Pregnancy
- ☐ Immunosuppressive disease or immunosuppressive treatment
- ☐ Diabetes
- ☐ Sickle Cell disease
- ☐ Chronic kidney disease
- ☐ Obesity or being overweight (BMI ≥ 25 or if age 12-17 have BMI ≥ 85th percentile for their age and gender)
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Cerebrovascular disease (e.g. history of stroke)
- ☐ Chronic liver disease
- ☐ Active cancer
- ☐ Chronic obstructive pulmonary disease, moderate-to-severe asthma or other chronic respiratory disease.
- ☐ Neurodevelopmental disorders (for example, cerebral palsy)
- ☐ Medically related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)
- ☐ **OR** is deemed by a health care provider to have other medical conditions or factors that place the patient at high risk for progression to severe COVID-19

Inclusion criteria (all must be true to qualify for therapy):

- ☐ Not currently hospitalized due to COVID-19
- ☐ Not initiated on oxygen therapy due to COVID-19
- ☐ For those on chronic oxygen therapy, baseline oxygen flow rate was not increased due to COVID-19
- ☐ Patient ≥ 12 years old
- ☐ Patient ≥ 40 kg
- ☐ Patient has a positive COVID test result **(Date: _____)**

For Remdesivir use the patient must meet the following additional criteria (all must be true to qualify):

- ☐ Patient has aspartate aminotransferase (AST) and alanine aminotransferase (ALT) levels no higher than 5 times the upper limit of normal within the last 90 days
- ☐ Patient has an estimated glomerular filtration rate (eGFR) 30 or greater consistently within the last 90 days
- ☐ Patient is not breast feeding
- ☐ Patient is otherwise unable to receive nirmaltrevir/ritonavir (Paxlovid®) due to contraindications, drug interactions or unavailability

☐ **Drug Order:** DAY 1: Remdesivir 200mg IV once, given over 30 minutes
DAY 2 and DAY 3: Remdesivir 100mg IV daily for 2 doses, given over 30 minutes each
Observe for 1 hour following each infusion and then discharge. Treat any allergic or infusion reactions per protocol. Maintain IV access until therapy is complete. Follow up with PCP with any questions or concerns.

Remdesivir will only be started Monday-Wednesday due to availability of appointments at the infusion center

Consent Statement for Remdesivir:

☐ As the patient's healthcare provider, I have communicated to the patient or parent/caregiver listed above, as age appropriate, the information consistent with the remdesivir package insert prior to the patient receiving outpatient remdesivir. I have documented in the patient's medical record that the patient/caregiver has been:

1. Given access to the remdesivir package insert, which can be accessed at: https://www.gilead.com/-/media/files/pdfs/medicines/covid-19/veklury/veklury_pi.pdf
2. Informed of alternatives to receiving outpatient remdesivir, and
3. Informed that the use of outpatient remdesivir is an off-label use of this medication.

☐ Patient/caregiver agrees to proceed with outpatient remdesivir treatment and verbal consent has been given.

For Bebtelovimab use the patient must meet the following criteria:

- ☐ Patient is otherwise unable to receive nirmaltrevir/ritonavir (Paxlovid®) due to contraindications, drug interactions or unavailability
- ☐ Patient is otherwise unable to receive remdesivir (Veklury®) due to contraindications, drug interactions, or unavailability

☐ **Drug Order:** Bebtelovimab 175mg IV once
Observe for 1 hour following administration and then discharge. Treat any allergic or infusion reactions per protocol. Follow up with PCP with any questions or concerns.

Consent Statement for Bebtelovimab:

☐ As the patient's healthcare provider, I have communicated to the patient or parent/caregiver listed above, as age appropriate, the information consistent with the "Fact Sheet for Patients, Parents and Caregivers" prior to the patient receiving monoclonal antibody products. I have documented in the patient's medical record that the patient/caregiver has been:

1. Given access to the "Fact Sheet for Patients, Parents and Caregivers"
   which can be accessed at: https://www.fda.gov/media/156153/download
2. Informed of alternatives to receiving monoclonal antibodies, and
3. Informed that monoclonal antibodies are unapproved drugs that are authorized for use under Emergency Use Authorizations.

☐ Patient/Caregiver agrees to proceed with COVID-19 antibody treatment and verbal consent has been given

Provider Signature: _____ **Date:** _____

Provider Printed Name: _____ **Provider DEA**: _____

Provider NPI: _____ **Provider License:** _____

Provider Address: _____

Provider Phone #: _____ **Provider Fax #:** _____

ONCE COMPLETED, PLEASE FAX TO:

Bremen Hospital Infusion Center
1020 High Road
Bremen, IN 46506
Fax: 574-546-3619

Incomplete / Illegible information may result in decreased prioritization; If appointment needs to be cancelled or there are additional questions, please call (574) 546-8001

Appointment Date 1: _____ **Appointment Time:** _____

Appointment Date 2 (if needed): _____ **Appointment Time:** _____

Appointment Date 3 (if needed): _____ **Appointment Time:** _____

Communicated with Patient Date: _____ **Time:** _____