SOUTHVIEW Medical Center
KETTERING HEALTH NETWORK

SOUTHVIEW OUTPATIENT INFUSION CENTER
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Bamlanivimab Order Form

Patient Name_____ **DOB**_____

Address_____

Phone # _____ **ICD-10 Diagnosis (must check box):** ☐ U07.1 – COVID-19

*****Bamlanivimab is NOT indicated for hospitalized patients, patients receiving supplemental oxygen, or patients on home oxygen who are requiring increased amounts of oxygen.*****

Patient Risk Factors:

☐ Age ≥ 65
☐ BMI ≥ 35
☐ Immunosuppressed*
☐ Chronic Kidney Disease*
☐ Diabetes Mellitus*
☐ Age ≥ 55 with COPD*
☐ Age ≥ 55 with HTN or CAD/CHF

*Immunosuppressed – patients on immunosuppressive medications or who have immunosuppressive disease (ex. CLL)
*CKD – stage 3 or above *Diabetes Mellitus – with medications *COPD – requiring home O2 (but at baseline flow rate)

Patients who have 1 or more of the above risk factors and are within 10 days of symptom onset will be eligible for bamlanivimab treatment.

Symptom Onset Date: _____ Symptoms: _____

Rx:

☐ IV Bamlanivimab 700mg added to 250 mL of 0.9% sodium chloride for total volume of 270 mL x 1 dose

- Infuse over 1 hour
- Administer using a 0.2-micron filter
- Observe patient for at least 1 hour following administration
- Flush line with normal saline after infusion to ensure complete dose is given

KHN infusion reaction protocol will be utilized if a patient has an infusion-related or hypersensitivity reaction.

Pre-meds (optional):

☐ Tylenol 650 mg po or ☐ Tylenol 1000 mg po
☐ Benadryl 25 mg po or ☐ Benadryl 25 mg IV
☐ Methylprednisolone 40 mg IV
☐ Other: _____

Consider premeds for patients with allergic tendencies or who have had allergic reactions to an immunoglobulin product.

Other Comments: _____

Prescriber_____ Date_____

Prescriber Signature_____

Address: _____ Phone _____ Fax: _____