INTEGRIS HEALTH

Patient Name:
DOB:
Patient Phone Number:
Height/Weight:

Bamlanivimab EUA Order Sheet

Allergies:

***MUST Provide Proof of Positive COVID Test if NOT in EPIC**

I certify the patient/legal representative was:

1. Informed that bamlanivimab is an unapproved drug authorized for use under this EUA
2. Instructed on risks, benefits, & alternatives to bamlanivimab
3. Given the "Fact Sheet for Patients, Parents and Caregivers" prior to administration
4. The patient meets appropriate criteria for administration
   - ≥12 years of age • ≥40kgs • mild to moderate Covid-19 disease
   - At high risk for progressing to severe COVID-19 and/or hospitalization
   - NOT hospitalized, requiring oxygen therapy due to Covid-19, or requiring 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
5. **Patient will be asked to sign an attestation document stating I have had this discussion with them.**

Date of symptom onset:____________________ **Date of positive test:** ____________________

Physician Signature Date Time

Printed Physician Name: ____________________ Physician Contact Number: ________________

QUALIFYING REASONS FOR ADMINISTRATION (*must choose at least one of the following*)

MEETS HIGH RISK CRITERIA:

[ ] BMI ≥35
[ ] Have chronic kidney disease
[ ] Have diabetes
[ ] Have immunosuppressive disease
[ ] Are currently receiving Immunosuppressive treatment
[ ] Are ≥65 years of age
[ ] Are ≥55 years of age AND have
- [ ] Cardiovascular disease **OR**
- [ ] Hypertension **OR**
- [ ] COPD/other chronic respiratory disease

[ ] Are 12-17 years of age, >40 kg AND have
- [ ] BMI ≥85th percentile for their age and gender based on CDC growth charts, **OR**
- [ ] Sickle Cell Disease, **OR**
- [ ] Congenital or acquired heart disease, **OR**
- [ ] Neurodevelopmental disorders, i.e. Cerebral Palsy, **OR**
- [ ] Medical-related technological dependence, i.e. tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID- 19), **OR**
- [ ] Asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

ORDERS

- Bamlanivimab Therapy Plan: Bamlanivimab 700 mg IV infusion over 60 minutes as soon as possible after positive viral test for SARS-CoV-2 and *within 10 days of symptom onset.* **Diagnosis Code: U07.1 COVID-19 virus infection**
- Monitor patient during infusion and observe patient for at least 1 hour after infusion is complete.
- Instruct patient to continue to self-isolate and use infection control measures according to CDC guidelines.

Physician Signature Date Time

Metro AIC: Fax: 405-815-6448 Phone: 405-604-6201

Enid: Fax: 580-548-1764 Phone: 580-616-7655

Miami/Grove: Fax 918-540-7266 Phone: 918-540-7216

Patient Label
Patient Name:
MRN:
DOB:

INT-5513 rev1/21 Order