NATIONAL INFUSION CENTER ASSOCIATION

Patient Name:

DOB: Age:

REGEN-COV™ (CASIRIVIMAB + IMDEVIMAB) INTRAVENOUS INFUSION ORDERS

Drug Allergies:	**Weight:** (must weigh at least 40 kg)
Date of Positive Test:	**Date of Symptom Onset:**

Primary diagnosis: ☑ U07.1 COVID-19 infection

Diagnoses placing patient at high-risk for severe COVID-19 illness- include ICD-10 code(s) and description(s):

Prescriber must indicate *all* of the following requirements have been met:

☐ Patient/caregiver has been given the Fact Sheet for Patients and Parents/Caregivers

☐ Patient/caregiver has been informed of alternatives to receiving REGEN-COV™

☐ Patient/caregiver has been informed that REGEN-COV™ is an unapproved product that is authorized for use under an Emergency Use Authorization.

Pre-Infusion:

☑ Obtain baseline vital signs

☑ Establish vascular access

Infusion Orders:

☑ If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

☑ Using dilution and administration instructions per table below, add **casirivimab 600 mg/5 mL AND imdevimab 600 mg/5 mL** to prefilled bag of **0.9% sodium chloride** and administer **intravenously** using a sterile, in-line, low protein-binding **0.2-micron filter.**

☑ May use any diluent volume (and associated infusion rate) permitted per EUA unless prohibited by prescriber below.

Prescriber: If patient requires specific diluent volumes/infusion rates, check appropriate box at right to indicate desired selection.

If no box is checked, administering clinician will use facility protocol to determine diluent volume/infusion rate per EUA.

Diluent Volume	Total Volume to be Infused	MAXIMUM Infusion Rate	MINIMUM Infusion Time
☐ 50 mL	60 mL	210 mL/hr	20 minutes
☐ 100 mL	110 mL	310 mL/hr	21 minutes
☐ 150 mL	160 mL	310 mL/hr	31 minutes
☐ 250 mL	260 mL	310 mL/hr	50 minutes

Post-Infusion:

☑ Flush administration set with 0.9% sodium chloride to deliver residual volume.

☑ Leave IV in place for observation period; remove prior to discharge.

☑ **Monitor patient for hypersensitivity reaction for a period of 60 minutes following infusion.**

☑ Record vital signs immediately following infusion and prior to discharge.

☑ Provide patient with discharge instructions.

☑ Send record of treatment to prescriber at fax number below.

Prescriber Name (print): _____ Fax: _____

Prescriber signature: _____ Date: _____