



Dangerous Abbreviations

DO NOT USE

AU qd Od

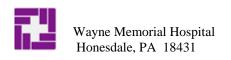
MS QD OD

MSO4 QOD U

MgSo4 SC IU

PHYSICIAN'S ORDERS Sotrovimab Treatment (for COVID-19 Outpatient Use Only)

ALLERGIES		Height	Weight		
		Date & Time:			
	Instructions For Sotrovimab	Prescribing			
1.	Patient must have a positive COVID-19 test. Medication sho	ould only be given	within 10 days of		
	symptom onset. Provider may repeat COVID test using a rapid test if concerned about previous				
	results. No specific time frame is recommended for positive	e COVID testing, how	wever it should be a		
	recent test (preferably within the last week).				
2. Patient must have Mild to Moderate symptoms and meet at least one high risk criteria. The pati					
2	cannot be on oxygen.				
3.	The <u>physician</u> must explain the risks and benefits of treatments phone is acceptable if witnessed. Consent is attached.	ent and obtain cons	ent. Consent over the		
4.	If possible the patient should receive the patient informatio	n from the prescrib	er at the time of the		
	discussion. If this is not possible, review content with the pa	•			
	the infusion site. Patient information is attached.	, ,	1,		
5.	<u>Complete the prescription.</u> The prescription <u>must be comp</u>	letely filled out or i	t will be returned to		
	the prescriber, possible causing the patient to miss the trea	tment window! The	prescription form is		
	attached				
6.					
7. 8.	Hospital will contact the patient if prescheduling infusion. The patient should be advised to expect to spend 3 to 4 hou	ırs at our infusion si	te		
0.	The patient should be davised to expect to spend 5 to 4 hou	in a cour initiation s	te.		
	****CONSENT REQUIR	ED****			
DOB:_	Preferred Contact Number:				
(Must	be at least 18 years old)				
	Alternate Contact Number:				
Date of (+) Positive COVID Test:					
Date of Symptom Onset:(must be within 5 days)					
Weight Over 40KG (88 lbs): ☐ Yes ☐ No (Please Check One)					
Symptoms: Mild Moderate (Please Check One)					





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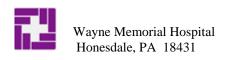
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Please Check All That Apply					
 Age ≥55 years Diabetes Obesity (BMI >30 kg/m²) Chronic Kidney Disease Congestive heart failure Chronic Obstructive pulmonary disease Moderate to severe asthma 					
****PRESCRIPTION****					
Sotrovimab 500mg (8 mL) in 100 ml 0.9% Sodium Chloride IV once over 30 minutes Instructions:					
instructions.					
Remove one Sotrovimab vial of from the refrigerator and allow it to sit at room temperature for 15 minutes.					
Do not shake or heat up the vials. Inspect them for particulates. The vials should be clear and colorless to slightly yellow or slightly brown.					
3. Once at room temperature, gently swirl the vial without shaking then remove 8 ml from the Sotrovimab vial and inject the 8 mL into a 100 mL bag of normal saline. Discard any remaining solution in the vials.					
4. Gently rock the bag back and forth 3-5 times to mix without shaking. Do not invert the infusion bag. Try to prevent forming bubbles.					
5. If not administered immediately, the diluted solution is good for 24 hours refrigerated and 6 hours at room temperature. If stored in refrigerator, allow to reach room temperature before administration.					
Administration:					
Attach a 0.2 micron filter to the infusion set if tubing is not filtered already and prime the tubing.					
Administer mixed medication immediately by infusing at a rate of 216 ml/hour (30 minutes) via infusion pump.					
3. Flush the line with 0.9% Sodium Chloride solution post-infusion to ensure full delivery of dose.					
4. Monitor patient during infusion and 1 hour post completion for signs and symptoms of an allergic or anaphylactic reaction.					
5. Follow anaphylaxis protocol for allergic reaction.					





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\V.O./T.O.	Physician Name:	e: Orders Read Back and Verified		
Physician Signature		Date	Time	
Nurse's Signature		Date	Time	

Fax to: 570-253-8634