Wayne Memorial Hospital
Honesdale, PA 18431

* P H Y O R D E R *

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 should 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 COVID testing, however 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 patient cannot be on oxygen.
3. The ***physician*** must explain the risks and benefits of treatment and obtain consent. Consent over the phone is acceptable if witnessed. Consent is attached.
4. If possible the patient should receive the patient information from the prescriber at the time of the discussion. If this is not possible, review content with the patient. They patient will receive a copy at the infusion site. Patient information is attached.
5. **Complete the prescription.** The prescription **must be completely filled out** or it will be returned to the prescriber, possible causing the patient to miss the treatment window! The prescription form is attached
6. Fax the completed prescription and the consent form to the number at the bottom of the form.
7. Hospital will contact the patient if prescheduling infusion.
8. The patient should be advised to expect to spend 3 to 4 hours at our infusion site.

****CONSENT REQUIRED****

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)

Affix Patient Label

Or patient name/DOB

Wayne Memorial Hospital
Honesdale, PA 18431

* P H Y O R D E R *

Dangerous Abbreviations		
DO NOT USE		
AU	qd	Od
MS	QD	OD
MSO4	QOD	U
MgSo4	SC	IU

Please Check All That Apply

- ☐ Age ≥55 years
- ☐ Diabetes
- ☐ Obesity (BMI >30 kg/m^2)
- ☐ 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:

		1. Remove one Sotrovimab vial of from the refrigerator and allow it to sit at room temperature for 15 minutes.
		2. 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:

		1. Attach a 0.2 micron filter to the infusion set if tubing is not filtered already and prime the tubing.
		2. 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.

Affix Patient Label

Or patient name/DOB

Wayne Memorial Hospital
Honesdale, PA 18431

* P H Y O R D E R *

Dangerous Abbreviations		
DO NOT USE		
AU	qd	Od
MS	QD	OD
MSO4	QOD	U
MgSo4	SC	IU

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

Fax to: 570-253-8634

Affix Patient Label

Or patient name/DOB