



Dangerous Abbreviations **DO NOT USE**AU qd Od

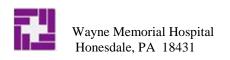
MS QD OD

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.	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					
2.	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.	•					
4.	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					
5.	 the infusion site. Patient information is attached. 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 					
6	attached					
7.	 Fax the completed prescription and the consent form to the number at the bottom of the form. Hospital will contact the patient if prescheduling infusion. 					
8.						
****CONSENT REQUIRED****						
DOB:	DOB: Preferred Contact Number:					
(Must	(Must be at least 18 years old)					
Alternate Contact Number:						
Date of (+) Positive COVID Test: (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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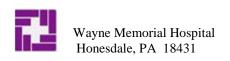
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Please Check All That Apply			
 Age ≥55 years Diabetes Obesity (BMI >30 kg/m²) Chronic Kidney Disease Congestive heart failure Chronic Obstructive pulmonary disease Moderate to severe asthma 			
⊠ Sotrovi	****PRESCRIPTION**** imab 500mg (8 mL) in 100 ml 0.9% Sodium Chloride IV once over 30 minutes		
Instructions:	That Sooning (5 mz) in 100 mil 0.5% Socialin emonae iv once over 50 milliates		
	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	<u>):</u>		
	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.		





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				\ <u>-</u>	
		5. Follow anaphylaxis protocol for allergic reaction.			
\V.O./T.O.		Physician Name:		☐ Orders Read Back and Verified	
Physician Signature			Date	Time	
Nurse's Signature			Date	Time	

Fax to: 570-251-6687





INFORMED CONSENT OFF LABEL MEDICATION USE FOR THE TREATMENT OF COVID19

It is very important to your doctor that you understand and consent to the treatment your doctor is rendering. You should be involved in any and all decisions concerning this treatment. Sign this form **only after you understand** the procedure, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered.

Medications (Sele	ct All To Be Prescribed):	
☐ Casirivima	ab and Imdevimab	☐ Other:
☐ Bamlanivi	mab & Etesevimab	
□ Sotrovima	b	
of COVID19. I un physician practice	nderstand that Off-label prescribing, a	fferent from one of the indications for which
information on use approved indicatio	e, dosage, and route of administration	FDA, my physician does not have tested that is provided in product labeling for cy of the unapproved use has not have been ls.
acknowledge that	o accept the potential risks that my there may be other, unknown risk f the above medications are not kno	physician has discussed with me. Is and that the long-term effects and risks of own.
of the potential risl		ves to this off label use. With this knowledge rations, I request that my doctor proceed with s.
	edge that the doctor has reviewed the questions on the subject of the use of	use of this medication with me in detail, and f this medication.
	low, I have had an opportunity to a risks of those alternatives.	sk the doctor all questions concerning risks,
Date Time	Signature of Patient/Authorized	Rep. Relationship of Authorized Rep.

Page 1 of 2 Affix Patient Label





INFORMED CONSENT OFF LABEL MEDICATION USE FOR THE TREATMENT OF COVID19

 □ The Patient/Authorized Representative has read this form or had it read to him/her. □ The Patient/Authorized Representative states that he/she understands this information □ The Patient/Authorized Representative has no further questions. 						
□ Verbal consent v	was given by the Patient/Au	thorized Representative (requires second Witness Signature)				
Date	Time	Signature of Witness				
Date	Time	Signature of Witness				
	CERTIFICAT	TION OF PHYSICIAN:				
		e risks associated with the alternatives of the discussed with the individual granting consent.				
Date	Time	Signature of Physician				
	IMPL	IED CONSENT				
patient or to preventhe patient or their a	t impairment of the patient	immediate treatment is required to preserve the life of a t's health; and it is impossible to obtain the consent of Unconscious patients are presumed under law to y.				
Date	Time	Signature of Physician				
Date	Time	Signature of Witness				

Page 2 of 2 Affix Patient Label