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 5 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)

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## 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. |



Affix Patient Label

Or patient name/DOB

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| | |
|---|---|
| | 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



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* C O N S E N T *

# 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 (Select All To Be Prescribed):**

- ☐ **Casirivimab and Imdevimab**
- ☐ **Bamlanivimab & Etesevimab**
- ☐ **Sotrovimab**
- ☐ **Other:** _____

_____

I understand and agree to the off-label use of **the above selected medications** in the management of COVID19. I understand that Off-label prescribing, also known as unapproved use, is the physician practice of prescribing a drug for a purpose different from one of the indications for which the product is approved by the Food and Drug Administration (FDA).

Because there has not been sufficient testing by the FDA, my physician does not have tested information on use, dosage, and route of administration that is provided in product labeling for approved indications. Furthermore, the safety and efficacy of the unapproved use has not have been established by adequate and well-controlled clinical trials.

**I am willing to accept the potential risks that my physician has discussed with me. I acknowledge that there may be other, unknown risks and that the long-term effects and risks of the off label use of the above medications are not known.**

I also understand that I have other medical alternatives to this off label use. With this knowledge of the potential risks, benefits, alternatives, and complications, I request that my doctor proceed with the off-label prescription the above selected medications.

I also acknowledge that the doctor has reviewed the use of this medication with me in detail, and answered all of my questions on the subject of the use of this medication.

**By signing below, I have had an opportunity to ask the doctor all questions concerning risks, alternatives, and risks of those alternatives.**

| Date | Time | Signature of Patient/Authorized Rep. | Relationship of Authorized Rep. |
|---|---|---|---|



Affix Patient Label

J:\FormsCommitteeApproved\CONSENTS\INFORMED CONSENTS\Informed Consent Off Label Rx Use To Treat Covid 19.docx FINAL: 3/26/2020; Rev. 1/15/21; 1/28/21, 4/23/21;12/20/21

Wayne Memorial Hospital

* C O N S E N T *

# 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 was given by the Patient/Authorized Representative **(requires second Witness Signature)**

| Date | Time | Signature of Witness |
|---|---|---|
| Date | Time | Signature of Witness |

## CERTIFICATION OF PHYSICIAN:

I hereby certify that the facts, risks, the risks associated with the alternatives of the procedure(s) described in this form have been discussed with the individual granting consent.

| Date | Time | Signature of Physician |
|---|---|---|

## IMPLIED CONSENT

Implied consent can be assumed when immediate treatment is required to preserve the life of a patient or to prevent impairment of the patient's health; and it is impossible to obtain the consent of the patient or their authorized representative. Unconscious patients are presumed under law to approve treatment that appears to be necessary.

| Date | Time | Signature of Physician |
|---|---|---|
| Date | Time | Signature of Witness |



Affix Patient Label

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