bebtelovimab (Lilly Monoclonal Antibody – EUA use)
Physician Referral and Prescription Order Form
Complete and Fax to WellSpan at (717)-255-0906
Questions: MAB Navigator Phone (717)-851-6226 (for offices/providers only)

Patient Information:

Name ____ Date of Birth ___/___/_____

Address ____________________________________ Patient Preferred Phone #: ____________

Sex: ☐ M ☐ F BMI: ___________ Drug Allergies: ____

Please send patient medical history, medication list, COVID-19 test results, and Insurance information

Diagnosis: COVID-19 (U07.1) **Is patient fully vaccinated? (please circle one):** YES NO

Date of positive COVID-19 test: ___________

Date of symptom onset: ____________ **Symptoms:** ____________________________________

Other pertinent details about course of illness: ____

____

Patient Indications – Please select all that apply for the qualifying patient (Must have at least one to qualify).
Adults and Adolescents, aged 12 to 17 years old, (weighing at least 88 pounds) who meet criteria.

☐ **Tier 1A**: Immunocompromised and not expected to mount adequate immune response
Examples: Taking rituximab, ocrelizumab, ofatumumab, alemtuzumab, Bruton tyrosine kinase inhibitors or immunosuppressive medications; Hematologic malignancies on active therapy; Lung transplant recipients; Within 1 year of receiving a solid-organ transplant (other than lung transplant); Solid-organ transplant recipients with recent treatment for acute rejection with T or B cell depleting agents; Severe combined immunodeficiencies; Untreated HIV who have a CD4 T lymphocyte cell count <50 cells/mm^3
Please list patient qualifier: ____

☐ **Tier 1B** ≥75 years, unvaccinated at the highest risk of severe disease (indicate in the table below which risk factors) (anyone unvaccinated, aged ≥65 years with additional risk factors)

Tier 2:
☐ ≥65 years AND unvaccinated at risk of severe disease (indicate in the table below which risk factors) **OR**
☐ <65 years AND unvaccinated with clinical risk factors (indicate in the table below which risk factors)

Clinical Risk Factors

☐ Body mass index 18 years and older (BMI) ≥30	☐ Cardiovascular disease (stroke, hypertension, congenital heart disease, cardiomyopathies, pulmonary hypertension)
☐ Age 12 to 17 with a BMI ≥85th percentile for age and gender based on CDC growth charts	☐ Sickle Cell Anemia
☐ Pregnancy	☐ Chronic lung disease (COPD, mod to severe asthma, interstitial lung disease, cystic fibrosis, pulmonary hypertension)
☐ Chronic kidney disease	☐ Immunosuppressive disease
☐ Chronic Liver Disease	
☐ Diabetes	
☐ Neurodevelopmental disorders	
☐ Medical-related technological dependence	

Limitations of USE: (If Patient meets any of the following – DO NOT Administer):

☐ NEW Requirement for Oxygen therapy due to COVID-19, OR
☐ Increased oxygen flow rate requirement due to COVID-19 when previously on oxygen therapy

MD/CRNP Signature (Required)____ **Date:** __________

*Physician Assistant requires a physician co-signature

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Patient Information:

Name ____ Date of Birth ___/___/_____

This medication is approved under emergency use. (All must be completed for administration of infusion)

- ☐ Patient and/or POA were provided with the patient EUA fact sheet (based on which drug is ordered)
- ☐ Patient and/or POA have been provided with the risks/benefits
  - Initial studies showed a reduction in risk of ED treatment and hospital admission
  - Risks include, but may not be limited to, chills, nausea, headache, shortness of breath, hypotension, wheezing, angioedema, rash, itching, muscle aches, or dizziness. In addition, risks of IV administration include brief pain, bleeding, bruising of the skin, soreness, swelling, and possible infection at the infusion site
  - Possible risk of reduced immune response to future COVID infection and to a COVID vaccine
- ☐ Treatment alternatives were discussed
- ☐ Patient or POA (if patient unable to consent) agree to proceed with treatment

Monoclonal Antibody:

Is patient positive for SARS-CoV-2 and within 7 days of symptom onset: YES NO

Pt must be within 7 days of symptoms to receive medication

☐ Administer **bebtelovimab 175 mg** intravenous over 30 seconds, ONCE

Emergency Management Orders:

[X] **sodium chloride 0.9%** 500 mL intravenous, As needed, Administer over 30 Minutes, for hypersensitivity reaction OR anaphylaxis, For 1 Dose

[X] **diphenhydramine (Benadryl)** 25 mg intravenous, As needed, for hypersensitivity reaction: give ONLY for flushing, rash, hives, pruritus, for 1 Dose

[X] **hydrocortisone sodium succinate (Solu-Cortef)** 100 mg intravenous, As needed, for hypersensitivity reaction OR anaphylaxis, for 1 Dose

[X] **albuterol inhaler** 2 puffs inhalation, as needed, wheezing, for anaphylaxis

[X] **famotidine** 20mg intravenous, As needed, for hypersensitivity reaction OR anaphylaxis, For 1 Dose

[X] **epinephrine** 0.3mg intramuscular, As needed, anaphylaxis, for 1 dose

Nursing Orders:

[X] Vital Signs prior to administration and after administration, per unit policy

[X] Notify provider: MILD to MODERATE signs and symptoms of hypersensitivity reaction: New onset of flushing, rash, hives, pruritis, hypotension, shortness of breath. SEVERE hypersensitivity reaction: New onset of stridor, respiratory distress, wheezing, loss of consciousness

[X] Nursing communication: STOP infusion for any signs or symptoms of hypersensitivity reaction

[X] Nursing Communication: Clinically monitor patient during administration and for at least 60 minutes post-infusion

Ordering Physician or Nurse Practitioner Information:

Physician or Nurse Practitioner Full Name: ____

NPI number __________________________

Address ____

City __________________________ State ___________ Zip ___________

Office/Practice Name & Contact Number _______________________________________

Preferred Contact Number for Questions by Clinical Team: __________________________

MD/CRNP Signature (Required)____ **Date:** __________

*Physician Assistant requires a physician co-signature