INFUSION ORDERS: COVID THERAPY: REMDESIVIR

Name:_____ DOB:_____

Date of symptom onset:_____ Medication Allergies: _____

Height: _____ inches Weight:_____kg Patient Phone #:_____

Remdesivir is FDA approved for outpatient treatment of mild-to-moderate COVID-19 disease in adults and pediatric patients (age 12 and older weighing at least 40 kg) with positive direct SARS-CoV-2 viral testing who are at high risk of progression to severe COVID-19, including hospitalization or death. Please mark the criteria that places this patient in the high risk category. Failure to indicate eligibility criteria may result in treatment delay or denial.

____ Age ≥ 65 years
____ Obesity (BMI >25 mg/m2, or if age 12-17, BMI > 85th percentile for age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)
____ Pregnancy
____ Diabetes
____ Chronic kidney disease
____ Immunosuppressive disease or immunosuppressive treatment
____ Cardiovascular disease (including congenital heart disease) or hypertension
____ Chronic lung disease (COPD, moderate to severe asthma, interstitial lung disease, CF, pulmonary hypertension)
____ Sickle cell disease
____ Neurodevelopment disorders
____ Dependence on medical-related technology (tracheostomy, gastrostomy, or positive pressure ventilation [not related to COVID-19])

***** Note patients should be symptomatic and within 7 days of symptom onset*****

REMDESIVIR TREATMENT:

_X_ Remdesivir 200 mg in 250 mL sodium chloride 0.9% infused over 30 minutes on day 1. Remdesivir 100 mg in 250 mL sodium chloride 0.9% infused over 30 minutes on days 2 and 3. Monitor for infusion reactions during administration.

_X_ After infusion is complete, flush the tubing with sodium chloride 0.9% injection to ensure delivery of the entire dose.

_X_ Observe patient for at least 1 hour after infusion is complete for infusion-related reactions.

_X_ Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1).

_X_ Ondansetron ODT 4 mg sublingual x 1 as needed for nausea.

My signature indicates that I have discussed the risks and benefits of this therapy.

Provider Sign:_____(Print):_____Date:_____Time:_____

Please fax a copy of the completed order to 406-447-2771

PATIENT IDENTIFICATION:

St. Peter's Health
2475 Broadway • Helena, MT 59601 (406) 442-2480

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