

## 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  $\geq$  65 years
- ☐ Obesity (BMI  $>25$  mg/m<sup>2</sup>, 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](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:

- ☒ 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.
- ☒ After infusion is complete, flush the tubing with sodium chloride 0.9% injection to ensure delivery of the entire dose.
- ☒ Observe patient for at least 1 hour after infusion is complete for infusion-related reactions.
- ☒ Adverse Reaction/Anaphylaxis Protocol if necessary (refer to form PO500-022-N-1).
- ☒ 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***

**St. Peter's Health**

**2475 Broadway • Helena, MT (406) 442-2480**

**INFUSION ORDERS: COVID THERAPY:  
REMDESIVIR**

PO500-079-N-1 (8-2022)



Patient Identification: