



COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Bamlanivimab/Etesevimab (Combination Therapy) Emergency Use Authorization (EUA) Standing Orders		
All items with an autocheck “√” are automatically initiated		
Name:	Date:	Time:
Date of Birth:		
Allergies:	Code Status: <input type="checkbox"/> Full <input type="checkbox"/> DNR <input type="checkbox"/> DNI	Wt:
Initial below in the box by each item:	I certify the patient/legal representative was (initial each item below):	
	Instructed on risks, benefits, & alternatives to Bamlanivimab/Etesevimab.	
	Given the “Fact Sheet for Patients, Parents, and Caregivers” prior to administration.	
	The patient meets the appropriate criteria for administration (check each item as applicable):	
<input type="checkbox"/> ≥ 12 years of age	<input type="checkbox"/> ≥ 40 kg (weight)	<input type="checkbox"/> Mild to moderate COVID-19 disease
<input type="checkbox"/> At high risk for progressing to severe COVID-19 and/or hospitalization.		
<input type="checkbox"/> NOT hospitalized due to COVID-19, or		
<input type="checkbox"/> DO NOT require oxygen therapy due to COVID-19, or		
<input type="checkbox"/> DO NOT require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related co-morbidity.		
Date of symptom onset:		Date of positive test:
Qualifying Reasons for Administration (Must choose at least one of the following):		
<input type="checkbox"/> BMI ≥ 35	<input type="checkbox"/> Have chronic kidney disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Immunosuppressive Disease	<input type="checkbox"/> Currently receiving immunosuppressive treatment	<input type="checkbox"/> Age ≥ 65 years
Are ≥ 55 years of age AND have <input type="checkbox"/> Cardiovascular disease, or <input type="checkbox"/> Hypertension, or <input type="checkbox"/> COPD/other chronic respiratory disease		
Are 12-17 years of age AND have (Check all that apply): <input type="checkbox"/> BMI ≥ 85 th percentile for their age and gender based on CDC growth charts, or <input type="checkbox"/> Sickle Cell Disease, or <input type="checkbox"/> Congenital or acquired heart disease, or <input type="checkbox"/> Neurodevelopmental disorders, i.e., Cerebral Palsy, or <input type="checkbox"/> Medical-related technological dependence, i.e., tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19), or <input type="checkbox"/> Asthma, reactive airway disease or other chronic respiratory disease that requires daily medication for control.		
ORDERS		
√ Bamlanivimab 700mg/Etesevimab 1400mg IV infusion over 70 minutes as soon as possible after positive viral test for SARS-CoV-2 and within 10 days of symptom onset. Once the infusion is complete, flush the tubing with 0.9% Sodium Chloride to ensure delivery of the dose.		
√ Administer infusion using 0.2 micron filter tubing.		
√ Obtain baseline VS (Temp, Pulse, Respiration, BP, O2 Sat) prior to infusion.		

Nurse Signature:				Time:		Date:		<input type="checkbox"/> TORB <input type="checkbox"/> VORB			
Provider Signature:				Time:		Date:					
Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead
U	Unit	1.0 mg	1 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

