ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. COVID-19 therapies are NOT authorized in patients with known hypersensitivity to any ingredient of the treatment.
3. To be eligible for treatment, patient must meet the criteria below:
    a. At least 3 kg or greater
    b. Documented positive PCR or antigen test
    c. Symptomatic COVID-19 infections
    d. Within 7 days of COVID-19 symptom onset
    e. Not on supplemental oxygen or requiring more oxygen than baseline if on chronic oxygen

AND at least one of the following

- ☐ Body mass index is 25 or greater
- ☐ Pregnancy
- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Immunosuppressive disease or Immunosuppressive treatment
- ☐ Sickle cell disease
- ☐ Cardiovascular disease (including congenital heart disease) or hypertension
- ☐ Chronic lung diseases
- ☐ Neurodevelopmental disorders or medical-related technological dependence
- ☐ Age greater than or equal to 65 years
- ☐ Cardiovascular disease, or hypertension, or COPD/other Chronic respiratory disease
- ☐ 12-17 years of age AND BMI greater than 85th percentile for age and gender based on CDC growth chart, OR sickle cell disease, OR congenital/acquired heart disease, OR medical-related technological dependence, OR neurodevelopmental disorder, OR medical related technological dependence, OR asthma/reactive airway/other chronic respiratory disease requiring daily medication for control

LABS:

- ☐ Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), Routine, ONCE, every_____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

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NURSING ORDERS:

1. TREATMENT PARAMETERS – Hold treatment and notify provider if patient does not meet criteria above in Guidelines for Ordering, or if treatment day #1 ALT is greater than or equal to 10 x ULN.
2. Contact provider if any concerns of adverse drug reactions.
3. Monitor patient during administration and observe for hypersensitivity reactions, including anaphylaxis, for 1 hour after administration.
4. May leave PIV in place for consecutive day infusions if clinically indicated and appropriate.
5. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

MEDICATIONS:

remdesivir (VEKLURY) in sodium chloride 0.9%, intravenous, ONCE, over 30 minutes

- ☐ 200 mg ONCE on day 1, followed by 100 mg DAILY on days 2 and 3
- ☐ 100 mg DAILY x _____ dose(s) to complete previously started treatment course

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

AS NEEDED MEDICATIONS:

1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching
3. sodium chloride 0.9% solution, intravenous, 500mL, AS NEEDED x1 dose, for TNF-alpha inhibitor infusion tolerability. Give concurrently with TNF-alpha inhibitor

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders