Monoclonal Antibody Treatments for Homebound Patients

Amedisys Home Health and Continuum RX have partnered to be able to provide monoclonal antibody infusions in the home for the treatment of mild to moderate coronavirus disease in adults *at high risk* of progressing to severe Covid-19. These patients must be infused *within 10 days* of the first appearance of symptoms. Currently the following offices are providing this service to your Medicare and Medicare Advantage patients:

- Harriman
- Jefferson City
- Maryville
- Jamestown
- Knoxville
- Oak Ridge

Patients meeting the above criteria will be treated as a home health referral, **therefore they must meet homebound status criteria**. *
Documentation required to begin the referral process includes patient demographics, Progress Note indicating the need for the home infusion, positive COVID test result and the signed order "Home Infusion Provider Monoclonal Antibody Order Form". Please fax the above to 877-438-9380.
Please contact me, or ContinuumRX at 865-525-4886 with any referrals or questions. Thank you for entrusting us to provide this aspect of care to your patients.

Sherri Ridenour RN, MPH
Care Transition Coordinator at UTMC / Amedisys Home Health
865-214-0230

* - Medicare beneficiaries will be considered homebound when advised by physician to remain home because of a confirmed or suspected case of COVID-19, or if the patient has a condition that makes them susceptible to contract COVID-19 if they leave the home.

- If a patient is homebound due to COVID-19 and needs skilled services, an HHA can provide those services under the Medicare Home Health Benefit.

CONTINUUMRx
Specialty Infusion Services

Fax: 877-438-9380

Home Infusion Provider Bamlanivimab/Etesevimab Order Form

Patient Name: _____ DOB: _____

Facility Name (if applicable): _____ Phone: _____

Address: _____ City: _____ State: _____

Physician: _____ Allergies: _____

Date of First Symptom Onset: _____ COVID Positive Result Date: _____

☐ Please send a copy of H&P and demographic information along with signed order

Patient Eligibility

Exclusion Criteria (Patients meeting any of the following criteria are NOT ELIGIBLE for bamlanivimab therapy)

a. who are hospitalized due to COVID-19
b. who require oxygen therapy due to COVID-19
c. who 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 comorbidity

By signing this order, physician verifies that none of the above criteria apply.

Inclusion Criteria: (at least one of the following criteria must be met to qualify for bamlanivimab therapy)

Check all that apply (replace letters with check boxes):

☐Patient is 12 years of age or older weighting at least 40 kg
Patient Weight: _____ kg Date: _____

Patients must have at least one of the following (select all that apply):

☐ Body Mass Index greater to or equal to 35
☐ Chronic Kidney Disease
☐ Diabetes
☐ Immunosuppressive Disease (i.e. CVID)
☐ Currently receiving immunosuppressive treatment
☐ ≥ 65 years of age
☐ ≥ 55 years of age, AND have at least one of the following: Cardiovascular disease, Hypertension, COPD or other respiratory disease
☐ Ages 12-17 AND have at least one of the following:
  ☐ BMI ≥ 85th percentile for the age & gender based on the CDC growth charts (https://www.cdc.gov/growthcharts/clinical_charts.htm)
  ☐ Sickle Cell Disease
  ☐ Congenital or Acquired heart disease
  ☐ Neurodevelopmental disorders
  ☐ Medical-related technological dependence (i.e. tracheostomy, gastrostomy, ventilator (not related to COVID-19)

☐ Asthma, Reactive airway, or other chronic respiratory disease requiring daily medication

Home Infusion Orders:

☐ Bamlanivimab ***700mg*** and etesevimab ***1400mg*** in 50ml 0.9% Sodium Chloride to be infused via gravity or infusion pump over 26 minutes (250m/hr) x 1 dose (Must use a 0.2 or 0.22 micron filter for administration) 1 vial of bamlanivimab (20ml) and 2 vials of etesevimab (40ml) per dose

☐ 50ml 0.9% Sodium Chloride

Once infusion is complete, flush the infusion line with 50ml 0.9% Sodium Chloride to ensure delivery of required dose.

☐ Anaphylaxis Kit if not available at infusion location

☐ Diphenhydramine 50mg/ml – Administer Diphenhydramine 50mg IV unless IV access is lost then can be IM x 1 PRN infusion reaction

☐ Epinephrine 1mg/ml – Administer Epinephrine 0.3mg SQ x 1 PRN anaphylactic drug reaction

Mild to Moderate Reactions: Signs and/or symptoms are transient, itching or rash

1. Stop flow of drug and notify physician
2. Follow emergency plan of care as outlined by MD or proceed as follows:
3. Benadryl (Diphenhydramine) 50mg IM x 1 in the event of nausea & vomiting
4. Notify the physician and pharmacist of suspected drug reaction
5. Document procedures as performed, time physician notified, clinical condition of patient, response to intervention
6. Notify the Pharmacy Director for the completion of an incident report.

Severe Reactions: Signs and/or symptoms such as wheezing, difficulty in breathing, presence of vascular signs and symptoms

1. Stop flow of medication
2. Rapidly evaluate the signs and symptoms that the patient is exhibiting
3. Follow emergency plan of care as outlined by MD or proceed as following the standard protocol
    a. Activate EMS
    b. Administer medications, as directed
    c. Maintain airway
    d. Begin CPR in the event of cardiopulmonary arrest
    e. Remain with the patient until EMS arrives and assumes responsibility

Additional Infusion Drug Orders

1. _____

Vascular Access Device (VAD) Orders:

Flush Protocol: _____

0.9% NS: ____ml Instructions: __SASH_____

Heparin __u/ml; ___ml Instructions: __SASH_____

Peripheral Vascular Access Device: Skilled nursing to assess and insert peripheral access device for administration of bamalanivimab.

Other: _____

Clinical Services:
Pharmacy Services: Assessment of patient eligibility, administration method, education on medication side effects, interactions, adverse reactions, and infusion-related reactions.
Nursing Services: Skilled nursing to administer bamlanivimab, patient assessment, and monitoring.

Physician Signature: _____

Date: _____