Davis Hospital and Medical Center
Jordan Valley Medical Center
Jordan Valley Medical Center-West Valley
Mountain Point Medical Center
Salt Lake Regional Medical Center
STEWARD FAMILY HOSPITALS

# COVID-19 Monoclonal Antibody PHYSICIAN ORDERS

**Fax to:**
Davis Hospital – 801-807-7665 Attention House Supervision

**Call to schedule appointment:**
Davis Hospital – 801-807-7008

Patient Name: _____ DOB ____/____/_____

Patient phone number: _____ Allergies_____

Primary Diagnosis: _____ Dx Code: _____

Please *circle* the points appropriate to the patient's risk factors and total at the bottom of the table.

**Monoclonal Antibody:**

[ ] Bamlanivimab 700mg IV once

**OR**

[ ] Casirivimab 1200mg and Imdevimab 1200mg IV once

**Pre Meds:**

[ ] Tylenol 650mg PO once

[ ] Diphenhydramine 25mg PO once

| Demographic Risk Factors | Points |
|---|---|
| Male | 1 |
| Age | 0.5 for every decade: 12-20=1, 21-30=1.5, 31-40=2, 41-50=2.5, 51-60=3, 61-70=3.5, 71-80=4, 81-90=4.5, 91-100=5, >100=5.5 |
| Non-White Race or Hispanic/Latinx Ethnicity | 2 |
| **Highest-Risk Comorbidities** | |
| Diabetes mellitus | 2 |
| Severely Immunocompromised | 2 |
| Obesity (BMI>30) | 2 |
| **Other High-Risk Comorbidities** | |
| Hypertension | 1 |
| Coronary artery disease | 1 |
| Cardiac Arrhythmia | 1 |
| Congestive Heart Failure | 1 |
| Chronic Kidney Disease | 1 |
| Chronic Pulmonary Disease | 1 |
| Chronic Liver Disease | 1 |
| Cerebrovascular disease | 1 |
| Chronic Neurologic disease | 1 |
| **Symptom Risk Factor** | |
| New Shortness of Breath | 1 |
| **Total** | |

Provider Signature:_____ Date Ordered: _____

**Please fax this completed form along with the patient's demographic, H&P and any pertinent labs to numbers above as appropriate. Risk Factor total requirement will vary depending on medication availability.**