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Description generated with very high confidence 

**Dayton MMRS GMVEMSC**

**Greater Miami Valley EMS Council (GMVEMSC)**

**Just in Time Standing Order (JITSO)**

**Bamlanivimab (BAM) & Etesevimib: COVID-19 Monoclonal Antibody Administration**

**1/3/2022 – Paramedics Only**

Use of this JITSO is at the discretion of each agency and must be approved by the agency director and agency medical director. Monoclonal Antibody (mAb) administration is within the Ohio EMS scope of practice for the Paramedic level of certification only.

Paramedics are authorized, at the discretion of their agency, to administer mAbs in the following settings:

* At local (including hospital) or regional mAb administration sites.
* In congregate residential sites, especially those experiencing COVID-19 outbreaks.
* In homes and other locations including stations.

Delivering the therapy takes about two hours. Bamlanivimab and Etesevimab must be administered together by intravenous (IV) infusion only for treatment of symptomatic COVID-19. Treatment with mAbs should be started as soon as possible after the patient receives a positive test result for SARS-CoV-2 and must be within 10 days of symptom onset. For Post-Exposure Prophylaxis (PEP), intravenous administration is viewed as clinically equivalent.

**Indications:**

To receive mAbs, patients must meet all three of the following criteria:

* High-risk pediatric patients from birth to 12 years and older.
* Have had their first positive test for SARS-CoV-2 virus and onset of symptoms within the past 10 days.

Due to resource limitations, systems may modify internal criteria to prioritize mAbs effectively.

**Criteria for Identifying High Risk Individuals**

The following medical conditions or other factors may place adults and pediatric patients, including neonates, at higher risk for progression to severe COVID-19:

* Older age (for example age ≥65 years of age)
* Obesity or being overweight
* Pregnancy
* Chronic kidney disease
* Diabetes
* Immunosuppressive disease or immunosuppressive treatment
* Cardiovascular disease (including congenital heart disease) or hypertension
* Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis, and pulmonary hypertension)
* Sickle cell disease
* Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
* Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))
* Other medical conditions or factors (for example, race or ethnicity) that place a patient at high risk for progression to severe COVID-19.
* Authorization of mAb therapy is not limited to the medical conditions or factors listed above.

**Contraindications**

* Persons who are not within the 10 days following symptom onset or positive COVID-19 test
* Who are hospitalized due to COVID-19; OR
* Who require oxygen therapy due to COVID-19; OR
* Who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy; OR
* Who have received a prior dose of casirivimab and imdevimab, **bamlanivimab** and **etesevimib**, or sotrovimab.

**Limitations of Authorized Use**

* Post-exposure prophylaxis with bamlanivimab and etesevimab is not a substitute for vaccination against COVID-19.
* Bamlanivimab and etesevimab are not authorized for pre-exposure prophylaxis for prevention of COVID-19.

**Medication Administration:**

* Requires *physician* authorization for each patient. If mAb is ordered by another provider, EMS must have it countersigned by a physician.
* Wear appropriate PPE including gloves, eye, and face protection, and NIOSH-certified facepiece respirators or better (i.e., PAPRs).
* Provide the patient with the Fact Sheet and document their receipt of it. It can be downloaded here: <https://www.fda.gov/media/145612/download>
* Document that the therapy was discussed and the Fact Sheet was given to the patient or caregiver, that the patient was informed of alternatives, and that monoclonal antibodies are administered under an emergency use authorization.
* Prior to infusion, have the patient take **acetaminophen** (e.g., **Tylenol**®) **1,000 mg**, and advise the patient to repeat the dose every six hours for the next 24 hours.
  + If over age 65, **use a dose of 650 mg.**
  + Do not use acetaminophen if the patient has a history of hypersensitivity or liver disease.

**Dosage and Administration:**

Treatment:

* The dosage in adults (18 years and older) is bamlanivimab 700 mg and etesevimab 1,400mg. >20 kg to <40 kg: 350 mg bamlanivimab and 700 mg etesevimab.
* >12 kg to 20 kg: 175 mg bamlanivimab and 350 mg etesevimab.
* 1 kg to 12 kg: 12 mg/kg bamlanivimab and 24 mg/kg etesevimab.

**Dose Preparation and Administration:**

General Information

* Bamlanivimab and etesevimab are supplied in individual vials but are administered together.
* Inspect bamlanivimab and etesevimab vials visually for particulate matter and discoloration. Bamlanivimab and etesevimab are clear to opalescent and colorless to slightly yellow or slightly brown solutions.
* The prepared infusion solution should **not** be administered simultaneously with any other medication.
* If the infusion must be discontinued due to an infusion reaction, discard any unused product.
* **Clinically monitor patients during administration and observe patients for at least 1 hour after infusion is complete.**

**IV Infusion in Adults (≥18 years regardless of weight)**

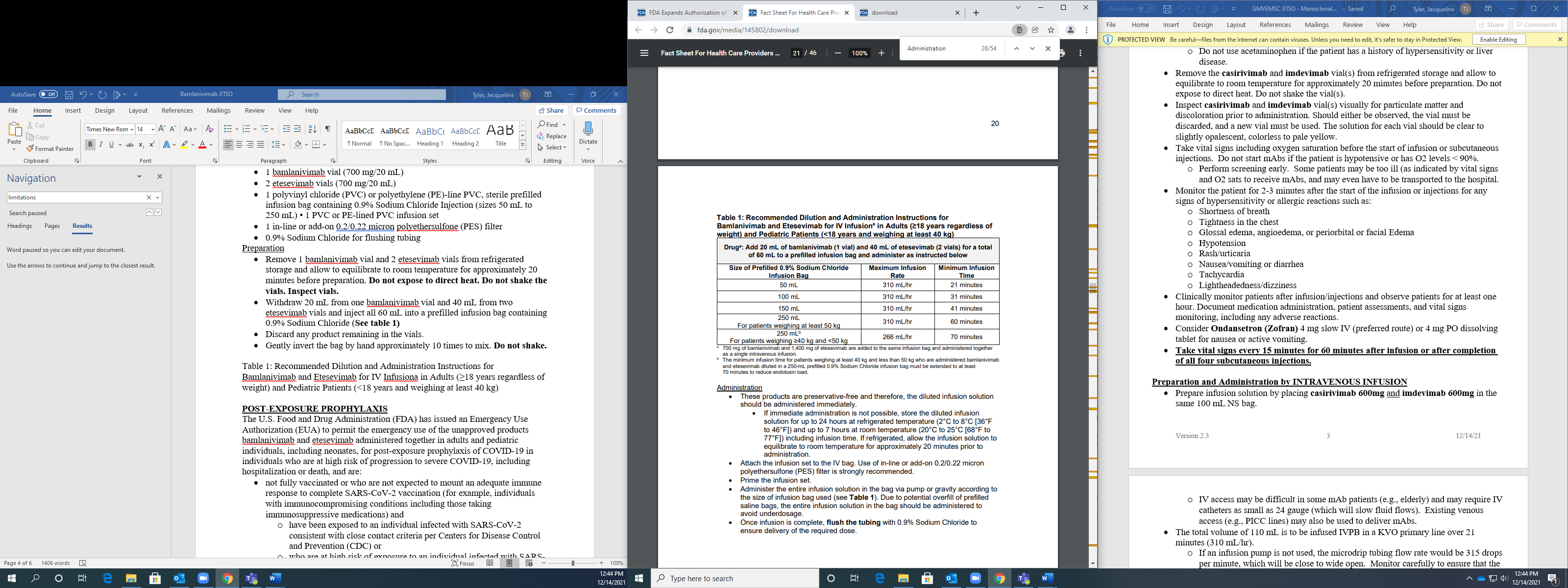
Materials Needed

* 1 bamlanivimab vial (700 mg/20 mL)
* 2 etesevimab vials (700 mg/20 mL)
* 1 sterile prefilled infusion bag of 0.9% Sodium Chloride (sizes 50 mL to 250 mL)
* 1 infusion set
* 1 in-line or add-on 0.2/0.22-micron filter
* 0.9% Sodium Chloride for flushing tubing

Preparation

* Remove 1 bamlanivimab vial and 2 etesevimab vials from refrigerated storage and allow to equilibrate to room temperature for approximately 20 minutes before preparation. **Do not expose to direct heat. Do not shake the vials. Inspect vials.**
* Withdraw 20 mL from one bamlanivimab vial and 40 mL from two etesevimab vials and inject all 60 mL into a prefilled infusion bag containing 0.9% Sodium Chloride (**See table 1).**
* Discard any product remaining in the vials.
* **Gently invert the bag by hand approximately 10 times to mix.** **Do not shake.**

Table 1: Recommended Dilution and Administration Instructions for Bamlanivimab and Etesevimab for IV Infusiona in Adults (≥18 years regardless of weight) and Pediatric Patients (<18 years and weighing at least 40 kg)



Administration

* These products are preservative-free and therefore, the diluted infusion solution should be administered immediately.
* If immediate administration is not possible, store the diluted infusion solution for up to 24 hours at refrigerated temperature (36°F to 46°F) and up to 7 hours at room temperature (68°F to 77°F) including infusion time. If refrigerated, allow the infusion solution to equilibrate to room temperature for approximately 20 minutes prior to administration.
* Attach the infusion set to the IV bag. Use a 0.2/0.22-micron filter.
* Prime the infusion set.
* Administer the entire infusion solution in the bag via pump or gravity according to the size of infusion bag used (**see Table 1**). Due to potential overfill of prefilled saline bags, the entire infusion solution in the bag should be administered to avoid underdosage.
* Once infusion is complete, **flush the tubing** with 0.9% Sodium Chloride to ensure delivery of the required dose.

**IV Infusion in Pediatric Patients (<18 years and weighing <40 kg)**

Materials Needed

|  |  |
| --- | --- |
| IV Bag | Syringe Pump |
| 1 bamlanivimab vial (700 mg/20 mL) | 1 bamlanivimab vial (700 mg/20 mL) |
| 1 etesevimab vial (700 mg/20 mL) | 1 etesevimab vial (700 mg/20 mL) |
| 1 sterile, empty 50-mL PVC or PE-lined PVC  infusion bag | 1 disposable syringe |
| 1 PVC or PE-lined PVC Infusion set | 1 syringe extension set |
| 1 in-line or add-on 0.2/0.22-micron PES filter | 1 syringe pump |
| 0.9% Sodium Chloride for flushing | 0.9% Sodium Chloride for flushing |

Single-dose vials may be used to prepare more than one pediatric dose; in addition, **pediatric doses do not need to be diluted for patients**

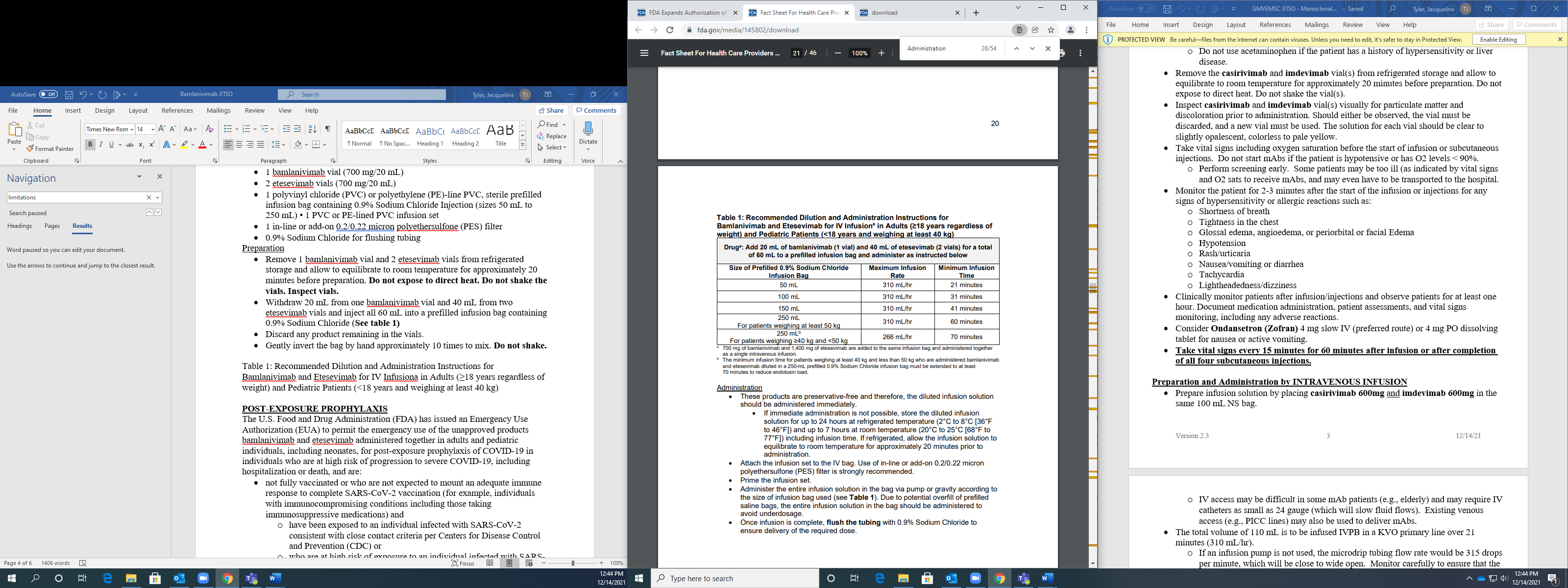
**Pediatric Dosing and Administration**

Treatment:

The dosage in pediatric patients (<18 years and weighting at least 40 kg) is bamlanivimab 700 mg and etesevimab 1,400mg. The dosage for pediatric patients weighing less than 40 kg will vary depending on body weight.

* >20 kg to <40 kg: 350 mg bamlanivimab and 700 mg etesevimab.
* >12 kg to 20 kg: 175 mg bamlanivimab and 350 mg etesevimab.
* 1 kg to 12 kg: 12 mg/kg bamlanivimab and 24 mg/kg etesevimab.

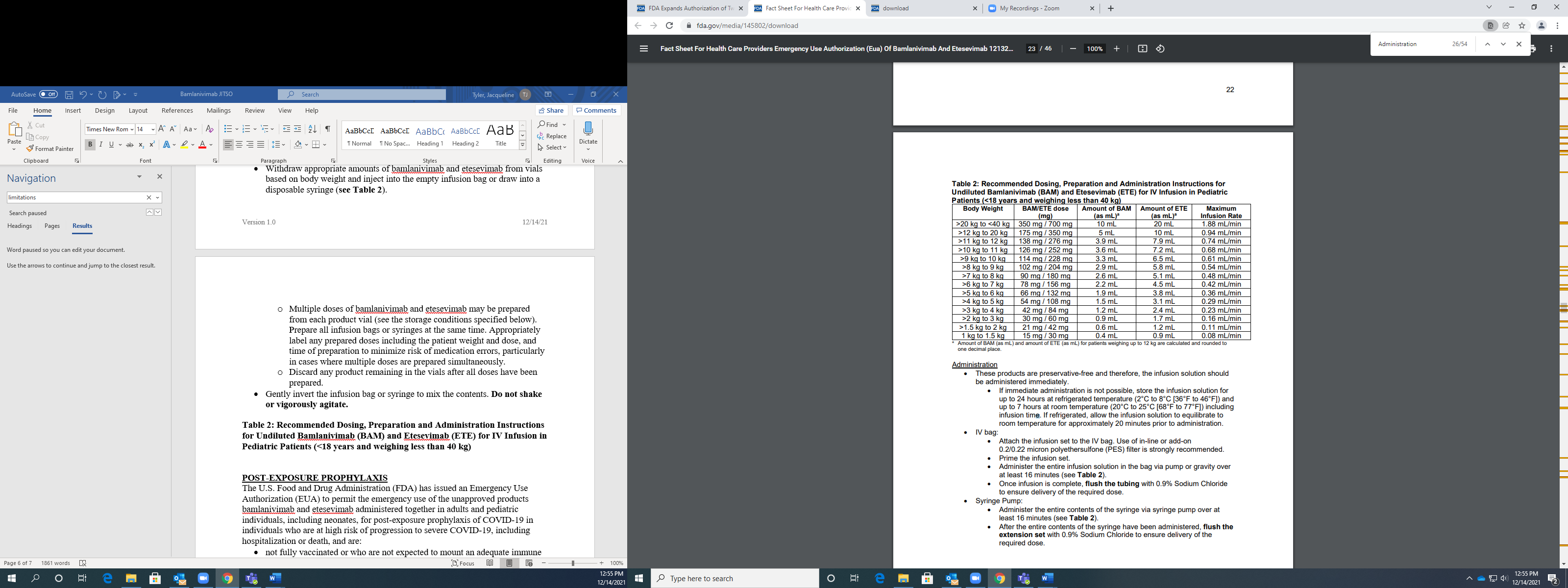
Recommended Dilution and Administration Instructions for Bamlanivimab and Etesevimab for IV Infusiona in Pediatric Patients (<18 years and weighing at least 40 kg)



Preparation

* Withdraw appropriate amounts of bamlanivimab and etesevimab from vials based on body weight and inject into the empty infusion bag or draw into a disposable syringe (**see Table 2**).
  + Multiple doses of bamlanivimab and etesevimab may be prepared from each product vial (see the storage conditions specified below). Prepare all infusion bags or syringes at the same time. Appropriately label any prepared doses including the patient weight and dose, and time of preparation to minimize risk of medication errors, particularly in cases where multiple doses are prepared simultaneously.
  + Discard any product remaining in the vials after all doses have been prepared.
* Gently invert the infusion bag or syringe to mix the contents. **Do not shake or vigorously agitate.**

**Table 2: Recommended Dosing, Preparation and Administration Instructions for Undiluted Bamlanivimab (BAM) and Etesevimab (ETE) for IV Infusion in Pediatric Patients (<18 years and weighing less than 40 kg)**



Administration

* These products are preservative-free and therefore, the infusion solution should be administered immediately.
  + If immediate administration is not possible, store the infusion solution for up to 24 hours at refrigerated temperature (2°C to 8°C [36°F to 46°F]) and up to 7 hours at room temperature (20°C to 25°C [68°F to 77°F]) including infusion time. If refrigerated, allow the infusion solution to equilibrate to room temperature for approximately 20 minutes prior to administration.
* IV bag:
  + Attach the infusion set to the IV bag. Use of in-line or add-on 0.2/0.22-micron polyether sulfone (PES) filter is strongly recommended.
  + Prime the infusion set.
  + Administer the entire infusion solution in the bag via pump or gravity over at least 21 minutes (**see Table 2).**
  + Once infusion is complete, **flush the tubing** with 0.9% Sodium Chloride to ensure delivery of the required dose.
* Syringe Pump:
  + Administer the entire contents of the syringe via syringe pump over at least 16 minutes (**see Table 2**).
  + After the entire contents of the syringe have been administered, **flush the extension** set with 0.9% Sodium Chloride to ensure delivery of the required dose.

**Management of adverse reactions:**

Patients should be monitored during administration and observe patients for at least 1 hour after infusion is completed.

* Serious hypersensitivity reactions, including anaphylaxis, have been observed with administration of bamlanivimab and etesevimab. If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medications and/or supportive care.
* Infusion-related reactions, occurring during the infusion and up to 24 hours after the infusion, have been observed with administration of bamlanivimab and etesevimab together. These reactions may be severe or life threatening.
* Signs and symptoms of infusion related reactions may include:
  + fever, difficulty breathing, reduced oxygen saturation, chills, fatigue, arrhythmia (e.g., atrial fibrillation, sinus tachycardia, bradycardia), chest pain or discomfort, weakness, altered mental status, nausea, headache, bronchospasm, hypotension, hypertension, angioedema, throat irritation, rash including urticaria, pruritus, myalgia, vasovagal reactions (e.g., pre-syncope, syncope), dizziness and diaphoresis.
* Consider slowing or stopping the infusion and administer appropriate medications and/or supportive care if an infusion-related reaction occurs.

**Equipment – *None of the below are provided by the Regional Hub for mAbs***

* Each site must have IV supplies and a GMVEMSC Drug Bag (or equivalent medications for treating anaphylaxis: epinephrine, diphenhydramine, and an IV corticosteroid).
* Each site must have oxygen and delivery devices, and resuscitation equipment.
* PPE must include gloves, gowns, eye, and face protection, and NIOSH-certified facepiece respirators or better (i.e., PAPRs).
* Infusion supplies should include infusion pumps (if used), appropriately sized syringes, absorbent underpads (blue pads).
* Sharps container and biohazard disposal bag.
* IV tubing and Micropore **filter.**
* Locking refrigerator with temperature monitoring capability if stored onsite.
* Thermometer probe covers (if required).
* Acetaminophen (e.g. Tylenol®).

**Storage and Handling:**

* **Bamlanivimab** and **Etesevimab** are preservative-free. Discard any unused portion after use.
* Store unopened vials at 2°C to 8°C (36°F to 46°F) in the original carton to protect from light.
* DO NOT FREEZE
* DO NOT SHAKE
* DO NOT EXPOSE TO DIRECT LIGHT
* The prepared infusion solution is intended to be used immediately.
  + If immediate administration is not possible, store infusion solution in the refrigerator at 2°C to 8°C (36°F to 46°F) for up to 24 hours and at room temperature (20°C to 25°C [68°F to 77°F]) and for up to 7 hours, including infusion time. If refrigerated, allow the infusion solution to equilibrate to room temperature prior to administration.

**Post-Exposure Prophylaxis (PEP):**

* Indicated for individuals who are not fully vaccinated or who are not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination (for example, individuals with immunocompromising conditions including those taking immunosuppressive medications) AND
  + have been exposed to an individual infected with SARS-CoV-2 consistent with close contact criteria per Centers for Disease Control and Prevention (CDC) OR
  + who are at high risk of exposure to an individual infected with SARS-CoV2 because of occurrence of SARS-CoV-2 infection in other individuals in the same institutional setting (for example, nursing homes, prisons).
* Limitations of Authorized Use
  + Bamlanivimab and etesevimab are not authorized for use in states, territories, and US jurisdictions in which the combined frequency of variants resistant to bamlanivimab and etesevimab exceeds 5%.
  + A list of states, territories, and US jurisdictions in which bamlanivimab and etesevimab are and are not currently authorized is available on the following FDA website: <https://www.fda.gov/media/151719/download>
* Post-exposure prophylaxis with bamlanivimab and etesevimab is not a substitute for vaccination against COVID-19.
* Bamlanivimab and etesevimab are **not** authorized for ***pre***-exposure prophylaxis for prevention of COVID-19.

**How Supplied for Use at EMS Sites other than hospitals or local/regional infusion centers**

* The U.S. Government supplies **Bamlanivimab** and **Etesevimab** for treatment and postexposure prophylaxis of COVID-19.
  + **This is only as supplies from the federal government are available.**
* EMS agencies planning to administer **Bamlanivimab (BAM) & Etesevimib** may obtain the drug from:
  + **Preferred method:** ODH has designated Miami Valley Hospital as a “Regional Hub” for mAbs. Regional hubs can obtain mAbs and distribute them to locations (including EMS agencies) using relatively small quantities.
    - Send an email with the completed “Premier Health Monoclonal Transfer Form” (attached) **to all four emails listed on the form:**

[gpkooken@premierhealth.com](mailto:gpkooken@premierhealth.com)

[jmspicer@premierhealth.com](mailto:jmspicer@premierhealth.com)

[lmharlow@premierhealth.com](mailto:lmharlow@premierhealth.com)

[krbrooks@premierhealth.com](mailto:krbrooks@premierhealth.com)

* + - Phone contact is Lindsay Harlow, office phone 937-208-3206
      * Backup contact is Andrea Wintraub, office phone 937-208-2153
    - If there is an urgent need to obtain mAbs for administration and you are unable to reach the personnel above, contact the Regional MMRS Coordinator David Gerstner at 937-776-4410.
    - As listed on the Transfer Form, include the monoclonal being requested (Bamlanivimab), quantity requested, date of pick up, contact information, and attach a copy of your agency’s State of Ohio license. Complete the “Transfer To:” section on the Monoclonal Transfer Form.
    - The **participating EMS agency must pick up mAbs** from Miami Valley Hospital. Deliveries of this medication cannot be made at this time.
    - mAbs provided from the Regional Hub at Miami Valley Hospital are not premixed. EMS will receive 2 vials per patient. The Regional Hub does not provide 100 cc bags of NS, filters, tubing, or bags of saline. Participating EMS agencies **or other agencies** (e.g., long-term care facilities) will be required to provide this equipment.
  + In limited circumstances, EMS may be able to obtain mAbs through a different hospital. Contact the EMS Coordinator at the hospital to discuss that.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | |  | |  |  |  |  | Monoclonal Transfer Form |
|  |  |  |  |  |

\*\*Ordering Instructions\*\*

Email the following:

Gary Kooken (Buyer) [gpkooken@premierhealth.com](mailto:gpkooken@premierhealth.com)

Jeannie Spicer (buyer) [jmspicer@premierhealth.com](mailto:jmspicer@premierhealth.com)

Lindsay Harlow (Manager) [lmharlow@premierhealth.com](mailto:lmharlow@premierhealth.com)

Kevin Brooks (Director) [krbrooks@premierhealth.com](mailto:krbrooks@premierhealth.com)

In the email indicate the following:

1. Monoclonal being requested

2. Quantity

3. Date of pick-up

4. Complete the "Transfer To" section below

5. Attach a copy of this Form and your State of Ohio license

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

TRANSFER FROM: TRANSFER TO:

Name: Miami Valley Hospital Name

Phone # (937) 208-2403 Phone #

Address: One Wyoming Street Address

City: Dayton State: OH Zip: 45409 City       State       Zip

TDDD # 020035050 TDDD #

     State of Ohio TDDD license has been verified, printed, and attached.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GMVEMSC Monoclonal Antibody Administration**

**Patient Screening/Referral & Order Set Form for EMS Locations**

**At Local, Regional, or Hospital Centers: use form provided for that site**

**Bamlanivimab (BAM) & Etesevimib EMERGENCY USE AUTHORIZATION SCREENING AND CONSENT FORM**

**SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** Last: |  |  | First: | Middle Initial: | |  |
| **Date of Birth:** Month | Day | Year |  | **Mobile Phone Number (Patient or Guardian): (** | | **)** |
| **Email:** |  |  |  |  | |  |
| **Address:** | | | | **Apt/Room #:** | |  |
| **City:** | | | | **State:** | **Zip:** |  |
| **Name of Legal Guardian:** Last: | | | | First: | Middle Initial: |  |
| **Sex (**Gender assigned at birth)   * Female * Male | **Race**   * American Indian or Alaska Native * Asian * Black or African American | | | * Native Hawaiian or other * Pacific Islander * White | * Other Asian ☐ Unknown * Other Nonwhite * Other Pacific Islander | **Ethnicity**   * Hispanic or Latino * Not Hispanic or Latino * Unknown |
| **Primary Insurance Carrier/Medicare/Medicaid** ID #: Grp #:  Insurance Company: Insurance Company Phone # Insured’s Name: Relationship: Insured’s Date of Birth **Secondary Insurance Carrier** ID #: Grp #:  Insurance Company: Insurance Company Phone #  Insured’s Name: Relationship: Insured’s Date of Birth | | | | | | |

**SECTION 3: Authorizing Physician Information**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_

Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Phone: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Physician Email/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION 3: PATIENT SCREENING**

|  |  |  |
| --- | --- | --- |
| **Please check YES or No for each question.** | **Yes** | **No** |
| 1. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days? |  |  |
| If yes, what was the date of your positive test or onset of symptoms (whichever is earliest)? | | |
| 2. Have you been exposed to someone with known COVID-19? |  |  |
| If yes, what was the date of this exposure? | | |
| 3. Have you had any COVID-19 antibody therapy within the last 28 days (for example, REGEN-COV, sotrovimab, bamlanivimab and etesevimab, COVID-19 convalescent plasma, etc.)? |  |  |
| 4. Are you 65 years of age or older? |  |  |
| 5. Are you overweight or have you been diagnosed with obesity (for example, is your BMI greater than 25 kg/m2, or if age 12- 17, is your BMI greater than or equal to the 85th percentile for your age and gender based on CDC growth charts)? |  |  |
| How much do you weigh? | | |
| 6. Are you pregnant? |  |  |
| 7. Do you have chronic kidney disease? |  |  |
| 8. Do you have diabetes? |  |  |
| 9. Do you have immunosuppressive disease or are you receiving immunosuppressive treatment? |  |  |
| 10. Do you have cardiovascular disease (including congenital heart disease) or hypertension? |  |  |
| 11. Do you have sickle cell disease? |  |  |
| 12. Do you have a neurodevelopmental disorder (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)? |  |  |
| 13. Do you have any medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))? |  |  |
| 14. Do you have any other high-risk conditions, like chronic lung diseases, a stoma, or other high-risk diseases? |  |  |
| If yes, describe: |  |  |
| 15. “Are you asymptomatic and unvaccinated, but have had a close COVID contact within the past 7 days?” |  |  |

* I certify that I am: (a) the patient and at least 12 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) legally authorized to consent for administration of Bamlanivimab (BAM) & Etesevimib for the patient named above. Further, I hereby give my consent to receive Bamlanivimab (BAM) & Etesevimib for me or the patient named above.
* I understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA, under an EUA for the treatment of mild or moderate coronavirus disease 2019 (COVID-19), and for post-exposure prophylaxis of COVID-19, in adult and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-COV-2 viral testing, and/or known exposure to a household contact diagnosed with positive SARS-COV-2 viral test, and who are at high risk for progression to severe COVID-19, including hospitalization and death; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
* I understand that it is not possible to predict all possible side effects or complications associated with receiving this treatment. I understand the risks and benefits associated with the above treatment and have received, read, and/or had explained to me the Emergency Use Authorization Fact Sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
* I acknowledge that I have been advised to remain at the treatment location during the administration of Bamlanivimab (BAM) & Etesevimib and for at least 1 hour after completion of intravenous infusion, or as directed for observation. If I experience a severe reaction, I will be treated at the site or treated and transported to the nearest hospital.
* On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the ***administering service*** and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the treatment listed above.
* I further authorize the ***administering service*** to submit a claim to my primary insurance carrier identified above on my behalf or on behalf of the patient named above for the administration of Bamlanivimab (BAM) & Etesevimib. I assign and request payment of authorized benefits to be made on my behalf to ***administering service*** with respect to the administration of Bamlanivimab (BAM) & Etesevimib. I understand that any payment for which I am financially responsible is due at the time of service or if ***administering service*** invoices, me after the time of service, upon receipt of such invoice.
* I acknowledge receipt of the Fact Sheet for Patients, Parents and Caregivers.

**Signature of Patient or Authorized Representative Date:**

**Print Name of Representative and Relationship to Person Receiving Bamlanivimab (BAM) & Etesevimib:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Site(s) (List all 4 for SQ) (RUE/LUE/RLE/LLE/RUQ/LUQ/RLQ/LLQ)** | **Route (IV)** | **Manufacturer (MVX)** | **Lot #**  **Unit of Use/Unit of Sale** | **Expiration Date** | **Date of EUA Fact Sheet** |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Administered at location: facility name/ID** |  |
| **Administered at location: Type** |  |
| **Administration Address:** |  |
| **Sending organization:** |  |

**Administering Service Name: Signature: Date:**