MATAGORDA REGIONAL MEDICAL CENTER

MRMC IV THERAPY SERVICES

COVID-19 Outpatient Therapy: Remdesivir IV Order Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ WT: _____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description)

_____COVID-19 _____ **Date of Diagnosis:** _____

INDICATIONS FOR USE: (PLEASE CHECK ALL THAT APPLY)

Date of Symptom Onset:_____

Date of (+) Covid Test:_____

- ☐ Adult and Pedi (age ≥12 yrs and weight ≥40 kg)
- ☐ Positive result of direct SARS-CoV-2 viral testing; within 7 days of symptom onset
- ☐ At high risk for progressing to severe COVID-19 and/or hospitalization as defined as ≥ 1 of the following:
  - ☐ Age ≥ 65
  - ☐ Pregnancy
  - ☐ BMI ≥25
  - ☐ BMI ≥85th percentile for age & gender based on CDC growth charts (age 12-17 years)
  - ☐ Chronic Kidney Disease
  - ☐ Diabetes
  - ☐ Sickle cell disease
  - ☐ Immunosuppressive disease or currently receiving immunosuppressive treatment
  - ☐ Cardiovascular Disease
  - ☐ Hypertension
  - ☐ Chronic lung disease (COPD, moderate to severe asthma, interstitial lung disease, cystic fibrosis, pulmonary hypertension)
  - ☐ Medical Related Tech. Dependency (trach, gastrostomy, positive pressure ventilation) not related to Covid-19
  - ☐ Congenital or acquired heart disease
  - ☐ Neurodevelopmental Disorders (cerebral palsy)
  - ☐ Other conditions or factors that place the patient at high risk for progression to severe COVID-19

DRUG	DOSE	ROUTE	FREQUENCY	DURATION
Remdesivir in 0.9%NS	**200mg IVPB on day 1, 100mg IVPB on day 2 & 3**	**IV over 1 hour day 1, 30 min day 2 & 3**	**qday**	**3 Days**

☒ **Prior to infusion, eGFR and AST/ALT will be required; may use lab results within previous 30 days.**

In Event of Hypersensitivity reaction :(Itching, rash, headache) May Give the following. In the event of severe reaction, transport patient to the Emergency Room.

	Medication	Dose	Route	FREQUENCY
X	Benadryl	25 mg	IV	Once
X	SoluMedrol	125 mg	IV	Once
X	Tylenol	650 mg	PO	Once

INSTRUCTIONS: **PATIENT CONTACT PHONE** _____

1. **Call the Pharmacy @ 979-241-3404 to see if drug is available. Mon-Fri 7am-4pm.**
2. **Fax the following to 979-241-3400**
   a. **Order Form**
   b. **Labs, if available (within 30 days)**
3. **MRMC Infusion Dept. will contact patient for registration and infusion time. DO NOT send patient to the hospital.**

Physician's Signature _____**Time**_____ **Date**_____

Fax completed form to MRMC Pharmacy at (979) 241-3400.
PLEASE include copies of: ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.