



COVID-19 Outpatient Therapy: Remdesivir IV Order Form

PATIENT INFORMATION

Last Name: First Name: MI DOB: HT: WT: Sex: 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, BMI >=25, Chronic Kidney 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

Table with 5 columns: DRUG (Remdesivir in 0.9%NS), DOSE (200mg IVPB on day 1, 100mg IVPB on day 2 & 3), ROUTE (IV over 1 hour day 1, 30 min day 2 & 3), FREQUENCY (qday), DURATION (3 Days)

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

Table with 4 columns: Medication, Dose, Route, FREQUENCY. Rows include Benadryl (25 mg, IV, Once), SoluMedrol (125 mg, IV, Once), 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. MPMC Infusion Dept. will contact patient for registration and infusion time. DO NOT send patient to the hospital.

Physician's Signature Time Date