Patient Label if Available

Adult Remdesivir for Outpatient COVID-19 Treatment

Last Name: _____ **First:** _____ **DOB:** _____ **Weight (kg):** _____

Allergies: _____ **Latex Precautions:** ☐ Yes ☐ No **Patient Phone:** _____

Insurance Provider: _____ **Policy Number:**_____ **Authorization Number:** _____

Medication Order:

☒ Remdesivir 200 mg IV on day 1

☒ Remdesivir 100 mg IV on day 2 and day 3 (by home infusion if feasible)

*Dose should be prepared in 250 ml NS and given over 30 minutes (may extend up to 120 minutes if concern for infusion reaction). Monitor patient for 1 hour following infusion for reaction.

Inclusion Criteria:

1. ☐ Patient is 16 years of age or older and weighs at least 40 kg (for pediatric patients send inquiries to OUMC.COVID.MAB.Approval@ouhealth.com with subject "pediatric")
2. ☐ Patient has risk factors for progression to severe COVID-19, such as age ≥ 60, hypertension, cardiovascular or cerebrovascular disease, diabetes mellitus, obesity (a body-mass index ≥30), immune compromise, chronic mild or moderate kidney disease, chronic liver disease, chronic lung disease, current cancer, or sickle cell disease.

COVID-19 Vaccine History (Manufacturer and Date - write 'N/A' if patient has not received dose)**:**
Dose 1:_____ Dose 2:_____ Dose 3:_____

Is patient immunocompromised? ☐ Yes ☐ No

Information: This is an off-label use of remdesivir. The PINETREE study showed a benefit of early 3-day remdesivir therapy when given within 7 days of symptom onset to patients at high-risk for progression to severe COVID-19. Efficacy outside of this patient population was not assessed. Package insert recommends lab work to assess renal and liver function and prothrombin time. Labs are the responsibility of the prescriber.

Fax Completed Form to: 1-866-743-2751

Or Email to: OUMC.COVID.MAB.Approval@ouhealth.com

For questions providers may contact OU Edmond Pharmacy at 405-359-5333

Telephone or verbal order:

☐ Yes ☐ No
Read Back and Clarified.

(Nurse Name, Date and Time)

Physician Signature Date Time

Physician Printed Name Physician Cell Phone

OUH Central Scheduling to complete below line:

Scheduled Clinic Site: ☐ O'Donaghue ☐ OCH 8th Floor ☐ EMC **Date:** **Time:**