St. Clair Health

St. Clair Hospital

COVID-19 Remdesivir Infusion Patient Reservation Checklist

Physicians requesting the use of Remdesivir currently approved under Emergency Use Authorization (EUA) must fax the following information to the St. Clair Hospital Pharmacy Department at **412-942-1420**. Each case will be reviewed per institution and FDA qualification criteria by a multidisciplinary team. Home tests will not be accepted due to concerns with test accuracy. New approvals will only occur on a **Monday-Wednesday** schedule due to patient scheduling.

Please answer the following questions completely:

Patient Name: _____

Physician Office Name: _____

Prescribing Physician: _____

Physician Office Phone Number: _____

Physician Office Fax Number: _____

Please return all three of the following with this reservation checklist:

☐ SARS-CoV-2 Positive Test Copy (home tests will **not** be accepted)

☐ Completed COVID-19 Remdesivir Infusion Patient Consent Form

☐ Completed COVID-19 Remdesivir Order Set

☐ SARS-CoV-2 Vaccine status (check one): ☐Vaccinated ☐Unvaccinated

Failure to send the completed information above will result in the patient not being reviewed for Remdesivir infusion consideration.

Patient Name: _____

Date of Birth: _____

Phone Number: _____

St. Clair Hospital
Pittsburgh, PA 15243

COVID-19 Outpatient Remdesivir Order Set

Physicians requesting the use of approved outpatient Remdesivir (*Veklury*) therapy under Emergency Use Authorization (EUA) must complete this order set for patient consideration. Patients will be reviewed by a multidisciplinary team, who will provide approval or denial. Approvals for new start therapy will occur only **Monday-Wednesday**. The following questions must be answered by the requesting physician prior to authorization process:

Criteria for Use:

1. **SARS-CoV-2 Positive Test** ☐**Yes** ☐**No**
   a. Patient must have direct positive test
2. **Outpatient Status** ☐**Yes** ☐**No**
   a. Patient is not admitted and does not require hospitalization
3. **Supplemental Oxygen Status** ☐**Yes** ☐**No**
   a. Patient is at baseline oxygenation status
4. **High Risk Status** ☐**Yes** ☐**No**
   a. Patient has one of the following risk factors (**please circle criteria**):
      i. Age ≥ 60, BMI ≥ 25, CKD, diabetes, immunosuppressive disease, receiving immunosuppressive treatment, pregnancy, cardiovascular disease, hypertension, COPD/other respiratory disease, sickle cell disease, neurodevelopmental disorders, and medical-related technological dependence (tracheostomy, gastrostomy, or positive pressure ventilation) OR
      ii. Adolescents 12-17 years of age, pediatric patients weighing 3.5 kg to less than 40 kg or pediatric patients less than 12 years of age weighing at least 3.5 kg who:
      Provide risk factors here: _____.
5. **Duration of Symptoms ≤ 7 days** ☐**Yes** ☐**No**
   a. Date of symptom onset :_____ (**must fill in date)**

If approved by multidisciplinary team, patient will be scheduled and receive the following:

☒ Diphenhydramine 25 mg IV push x 1 dose **PRN infusion reaction**
☒ Pharmacy to select appropriate dosing:
☐ Remdesivir 200 mg in 100 mL NSS over 30 minutes on day 1, followed by Remdesivir 100 mg in 100 mL NSS over 30 minutes on days 2 and 3
☐ Pediatric weight-based dosing (3.5 kg to < 40 kg): 5 mg/kg day 1 followed by 2.5 mg/kg days 2-3.
Day 1: _____ Day 2: _____ Day 3: _____

Patient must start Remdesivir *(*Veklury) infusion by this date: _____

Prescribing physician to schedule patient for follow-up appointment 24-48 hours post infusion

Physician Signature:_____ Date: _____ Time: _____

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Authorization for EUA Remdesivir Infusion

1. I authorize Dr._____ and whomever he or she may designate as assistants, to order for the above-named patient the administration of the drug remdesivir, which is currently authorized for emergency use by the Food & Drug Administration (FDA).

2. I understand that remdesivir treatment is used in cases of COVID-19. Remdesivir is an investigational antiviral agent. An investigational agent is one that researchers are still studying to find out whether it's safe and effective. Some studies show that remdesivir may help patients get better sooner. Because remdesivir is investigational, the Food and Drug Administration (FDA) has not yet approved it for general use; however, the FDA has authorized emergency use of the drugs for use in cases of COVID-19 infection under 21 U.S.C. 360bbb-3 of the Food, Drug, and Administration Act.

3. I acknowledge that the nature, risks and consequences of the use of remdesivir and the possible alternatives to the treatment, including no treatment, and their nature, risks and consequences have been fully explained to me. Some of the known risks of this medication include, but are not limited to, back pain, chest tightness, chills, dark-colored urine, difficulty swallowing, fast heartbeat, flushing, headache, hives, itching, light-colored stools, nausea and vomiting. These can happen during and after the infusion and should be reported to my healthcare provider right away. These are not all the possible side effects. Serious and unexpected side effects may happen.

4. I acknowledge that I have received the appropriate drug information sheet titled "Remdesivir Fact Sheet for Patients, Parents and Caregivers", that I have been given an opportunity to ask questions about the treatment and that all questions which I have asked have been answered to my satisfaction.

5. I acknowledge that there may be unforeseen complications, injury, or even death from both known and unknown causes associated with remdesivir administration.

6. I acknowledge that no guarantee or assurance has been made as to the result or cure that might be obtained from the treatment.

Acknowledged by Dr _____ Date_____ Time_____
(Physician Signature required)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS, THAT THE EXPLANATIONS THEREIN REFERRED TO HAVE BEEN MADE CLEAR TO ME, THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTIONS OR COMPLETIONS HAVE BEEN FILLED IN, AND THAT I WISH TO GIVE THE ABOVE AUTHORIZATION AND ACKNOWLEDGEMENT.

Date _____ Time _____ _____
Patient's Signature

If this patient is unable to sign, complete the following lines:

This patient unable to sign because _____

_____ _____
Person Signing on Behalf of Patient Relationship to Patient

Date _____ Time _____ _____
Witness' Signature