COVID-19 Outpatient Therapies for Providers Requesting Administration at Connecticut Children's

Last Updated: 5/27/22

Patient may meet criteria for outpatient COVID-19 therapy (including monoclonal antibody infusions, prophylaxis, PO treatments, etc) under Emergency Use Authorization (EUA) or a fully FDA-approved medication

Initial Assessment by Requesting Provider:

- Requesting provider must, at minimum:
  - Make a best effort to confirm all inclusion criteria met under the EUA or fully FDA approved medication prescribing information
  - Provide basic information about medication, that it is an unapproved drug authorized for use under EUA (if applicable), and discuss if there are any alternatives available
  - At minimum, obtain consent that patient/family would like to proceed if Infectious Disease approval is given

Requesting Provider to Obtain Approval for Medication Administration/Dispensing at CT Children's:

- **Requesting Provider MUST complete the Outpatient COVID-19 Therapies Request Form – Appendix A**
- **Once the Request Form is complete:**
  - Internal providers:
    - Voalte Infectious Disease On Call to obtain approval to verbally discuss components of Request Form, or
    - Fax Request Form to Infectious Diseases at 860-545-9371
  - External providers: call One Call at 1-833-733-7669 (fax 860-837-9898 or 860-545-9502)
- **Once approval is obtained:**
  - Infectious Disease will take over care from requesting provider
  - Exception: Heme/onc will be managed by their own division once approval obtained

CT Children's Role:

- CT Children's Infectious Disease will:
  - Discuss "Fact Sheet for Patients, Parents and Caregivers" and any further questions family might have
  - Discuss alternatives and that medication is authorized under EUA (if applicable)
  - Confirm consent to treat with medication
  - Order medication
- If IV or IM medication:
  - To be preferentially given at St Mary's unless extenuating circumstances exist (main campus sedation suite or MS floors will then be used)
- If PO medication: Utilize **PO Paxlovid Ordering Guidance**

Post Treatment Recommendations – Requesting Provider Role

- **Post infusion care:**
  - Follow up with the patient to monitor for ongoing symptoms, worsening, etc.
  - Monitor for side effects for at least 1 week and report them according to EUA instructions. Specific side effects are listed in each EUA, if applicable.
  - For monoclonal antibodies, staying well hydrated will help mitigate minor side effects.
- **If infected with COVID-19:**
  - Ensure patient continues to adhere to CDC guidelines on isolation/quarantine.
  - Make note of exercise limitations post COVID infection. See **Cardiology Return to Play Algorithm** on CT Children's Clinical Pathway site.
- **Other Considerations:**
  - Make note of when patients are eligible for COVID-19 vaccination and the restrictions outlined by the EUA, if applicable.
  - Make note of what new medications are started while receiving ongoing therapies and if they will adversely interact with one another. See specific EUA for details.

Owners: Juan Salazar, MD | Ian Michelow, MD | Grace Hong, APRN

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Outpatient COVID-19 Therapy Request Form to Administer/Dispense at CT Children's
(Includes: monoclonal antibody, IV antiviral therapies)

*In order to provide safe and timely care for your patient, requesting providers are **required** to provide **all** of the information below. Incomplete requests may result in delayed, or denied, treatment.*

Patient's Name: _____

If the child is a CT Children's patient:

Patient's MRN: _____

Update in Epic: ☐ Allergies (including previous reactions to medications) ☐Medication ☐Problem List

If the child is not a patient of CT Children's:

Patient's DOB: _____

Patient's Recent Weight, Date Obtained: _____

Guardian/Caregiver Name and Phone Number: _____

Allergies (include previous reactions to medications):

Current medication list:

Past Medical History (include high risk criteria):

COVID-19 Information:

Is the family interested in receiving treatment for COVID-19? ☐ Yes ☐I haven't discussed it with them yet

If applicable, provide the following information:

Last COVID exposure _____ First positive COVID test _____ First day of symptoms _____

Symptoms and any changes in baseline therapies (if applicable):

☐I would like to speak with an ID specialist about available COVID-19 therapies

☐I would like to request a specific COVID-19 therapy (write out): _____

Location for Administration: ☐St. Mary's Hospital (Preferred) ☐Hartford, Main Campus (emergency only)

Requesting Provider Name: _____ **Phone Number:** _____

I, _____, attest that the above information provided is accurate, complete, and true to the best of my knowledge.

Signature of Requesting Physician: _____ **Date:** _____

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