Ontario Health atHome

Adult Intravenous Remdesivir Infusion Therapy Order Form

356 Oxford Street West London, ON N6H 1T3
Telephone: 1-800-811-5146 Fax: 519-472-4045

Important Instructions

Ministry of Health only provides coverage for a **maximum of three** doses for an eligible patient.

Determining and providing proof of patient eligibility for IV Remdesivir therapy is the Prescriber's responsibility, namely:

- The individual does not require hospitalization; AND
- The individual cannot take Paxlovid (nirmatrelvir and ritonavir), e.g., due to a drug interaction or contraindication; AND
- The individual has a positive COVID-19 test result (molecular or rapid antigen) and has had symptoms for fewer than 8 days at the time treatment is initiated (dose 1).

A current medication list must be sent along with a completed copy of this form.

Refer to product monograph for specific details related to lab values and contraindications for infusion.

Please complete the referral form in its entirety and fax completed form to Ontario Health atHome at **1-519-472-4045 or 1-855-223-2847**

Orders are processed between 8am 8pm (7days/week) and require a minimum 4 hour turnaround window. Referrals without sufficient information will be returned to the referral source with further direction.

Ontario Health atHome uses a 'Clinic First' approach to service delivery.

Patient information

Surname		First Name
Home Address		
City		Postal Code
Health Card Number	Version Code	Date of Birth (YYYY-Month-DD)
Phone Number		Other

Medical Information

Drug allergies (list ALL) ☐ No known drug allergies

Vascular Access Details (required for intravenous infusions)

○ Vascular access in place Date Inserted (YYYY-Month-DD): _____ Needle Gauge/Size: _____

○ Peripheral Line ○ Midline ○ Implanted Port ○ Central Line / Peripherally Inserted Central Catheter (PICC)

Number of lumens: _____ Inserted length: _____ cm ☐ Position confirmed on chest x-ray

○ Peripheral vascular access to be started in community

Note:

1. Nursing will change and manage peripheral IV line access, flushing, dressings and maintenance as per agency protocol.
2. Nursing will manage central IV line access, flushing, dressings and maintenance as per routine agency protocol unless otherwise instructed.

Surname	First Name	Health Card Number

Medication Orders

Clinical Indication for Medication

Symptomatic for COVID-19 - Tested Positive for COVID-19

Requires IV Remdesivir Treatment - Not eligible for Paxlovid

Symptom Onset Date (YYYY-Month-DD)	Date COVID-19 Testing Done (YYYY-Month-DD)	Type of Testing Done
		○ COVID RAT ○ COVID PCR

Treatment Orders

○ IV Remdesivir Standard Protocol: IV Remdesivir 200mg once on Day 1 then IV Remdesivir 100mg once daily x 2 days

OR

○ IV Remdesivir Specific Protocol for Dose 2 & 3: (please provide instructions)_____

First Dose of IV Remdesivir Standard Protocol Received (YYYY-Month-DD)	Requested Treatment Start Date (YYYY-Month-DD)	Requested Treatment End Date (YYYY-Month-DD)

Flush Protocol Orders (product monograph suggests a flushing with a **minimum of 30 mL** of sodium chloride 9mg/mL post infusion)

○ _____ (orders)

○ As per Nursing Agency Remdesivir policy

Dressing Change Instructions

○ Service provider to follow best practice

○ Other dressing change instructions:

_____ (orders)

Special Instructions

Ontario Health atHome First Dose IV Remdesivir Screener (adapted from Provincial Parenteral Screener)

When requesting first dose IV Remdesivir please complete risk assessment questions below.
If the patient has taken the prescribed medication in the past six (6) months without reaction, please answer all questions except for 2, 3, and 4.

	Yes	No
1. The patient is younger than 18 years old.	○	○
2. The patient has a history of serious adverse or allergic reaction to the prescribed medication or related compound.	○	○
3. The patient has a history of anaphylaxis of unknown origin or serious allergies.	○	○
4. The patient is taking a beta blocker.	○	○
5. The patient does not have someone 18+ years available to monitor/stay with patient for first 6 hours post medication administration.	○	○
6. The patient does not have access to a working telephone.	○	○
7. The patient does not have access to Emergency Medical Service or hospital within thirty (30) minutes.	○	○
8. The patient is taking one of the following: Chloroquine, Hydroxychloroquine or Rifampin.	○	○

If a 'Yes' answer is for any of the questions above, Nursing Service Provider and Prescriber will review and determine if treatment should continue in the community nursing clinic setting.

Referrer Details

Referrer Name	CPSO/CNO Registration	OHIP Billing Number

Phone Number	Fax Number

Office Address

City	Postal Code

Referrer Signature	Date Signed (YYYY-Month-DD)