EVUSHELD ORDER FORM FOR PRE-EXPOSURE PROPHYLAXIS
(complete all sections legibly)

Date &Time_____ Patient Name_____

DOB_____ Phone number _____

Allergy: _____ Address: _____

Evusheld (tixagevimab and cilgavimab) is available to patients who meet emergency use authorization (EUA) criteria.

Clinical Criteria and Data Requirements for Patient: (Must complete each item as appropriate)

- Weight of patient is >/= 40Kg : ____ Yes ____ No; if no, note the patient's weight _____
- Received prior infusion of monoclonal antibodies for COVID-19 infection: _____ Yes ____No; If yes, please indicate the name and when received _____
- Received or scheduled to receive COVID-19 vaccination _____ Yes ____No; if yes, when _____
- (if received, Evusheld should be administered at least 2 weeks after vaccination)
- Prior COVID-19 infection: _____ Yes (if yes, when_____); ____ No
- I confirm Evusheld is authorized for use in patients: _____ Yes ____ No
    - ☐ Patients must NOT be currently infected or having symptoms with COVID-19 **AND**
    - ☐ Patients must not have had a known recent exposure (within 14 days) to an individual infected with COVID-19.
- Additionally, patients must fall into one of the two categories below to qualify for treatment:
    - ☐ Patients with moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications for treatment, and who may not mount an adequate immune response to COVID-19 vaccination. Please specify_____

      OR
    - ☐ Patients in whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID19 vaccine component(s).

Dosing:

_____ Initial Dosing: Tixagevimab 300 mg and cilgavimab 300 mg as a single dose
_____ Repeat Dosing: For patients who initially received tixagevimab 150 mg and cilgavimab 150 mg (previously approved dose)

☐ If initial dose was ≤3 months ago: administer a follow-up dose of tixagevimab 150 mg and cilgavimab 150 mg

☐ If initial dose was >3 months ago: administer tixagevimab 300 mg and cilgavimab 300 mg

_____ (____)_____
Signature Cell Number (used for notifying of decisions and questions)

_____
Please Print Name

*****FAX COMPLETED FORM AND DEMOGRAPHICS TO 734-333-8005*****