SARS-CoV-2 Monoclonal Antibody Attachment Inhibitor
EVUSHELD (Tixagevimab/cilgavimab)

Date: _____

Patient Name: _____ DOB: _____

Practice Phone: _____ ICD-10 Code: _____

Diagnosis Description: _____

Dosing Regimens (Over 12 years of age and over 40 kg)

_____ Tixagevimab 150mg IM once + Cilgavimab 150mg IM once (may repeat in 6 months for a max of 2 total doses)

Monitoring

Observe patient for infusion-related reactions for at least 1 hour after post administration

Provider to answer the following questions:

1. Has patient given informed consent verbally to provider? ..... ☐ Yes ☐ No
2. Patient is 12 or older and 40kg or greater? ..... ☐ Yes ☐ No
3. Patient has negative screen for COVID symptoms and is negative for COVID exposure in past 14 days?
   ..... ☐ Yes ☐ No
4. Patient is up to date with COVID vaccination (completed vaccine regimen) **OR** a COVID-19 vaccine contraindication due to a severe allergy to the COVID-19 vaccine or one of its components
   ..... ☐ Yes ☐ No
5. Patient has received a COVID-19 vaccine within previous 2 weeks? ..... ☐ Yes ☐ No
6. Patient has a life expectancy of less than 6 months? ..... ☐ Yes ☐ No
7. Was patient given a copy of the "EUA 000104 Factsheet_Patients Parents and Caregivers_12.8.2021.pdf"
   ..... ☐ Yes ☐ No

PATIENT MUST MEET AT LEAST ONE CRITERIA FOR USE LISTED BELOW

Please check which criteria patient meets:

☐ Active treatment for solid tumor and hematologic malignancies

☐ Receipt of solid-organ transplant

☐ Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)

☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)

☐ Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)

☐ Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks), alkylating agents, antimetabolites, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell depleting agents)

PATIENTS WE ARE UNABLE TO TAKE REFERRALS FOR:

a. Treatment of, or post-exposure prophylaxis of, COVID-19
b. Individuals for whom COVID-19 vaccinations are recommended but who are not completely vaccinated (including boosters doses), unless the COVID vaccine is contraindicated for the individual
c. Individuals who have received a COVID-19 vaccine within the previous two weeks
d. Patients with life expectancy less than 6 months

Name of Office Contact Person: _____

Phone Number of Office Contact Person: _____

Provider Signature: _____

Provider Printed Name: _____

Date: _____

REMIT TO: *Karen McKerihan, MSN, NP-C*
Referral Fax Number: 843-890-5674
Phone: 843-572-4840 Ext 7025

IMPORTANT

Please include:

- This signed form
- A copy of most recent office note that provides supporting documentation of criteria patient meets for EVUSHELD administration
- Patient demographics sheet including any insurance information