Intramuscular EVUSHELD (tixagevimab co-packaged with cilgavimab) for Pre-exposure Prophylaxis for COVID-19: External Referral Form

Fax completed form and documents to 540-857-5309

Scheduling occurs AFTER all pages are received with all fields completed.

PATIENT INFORMATION

Patient's Full Name _____ Sex _____ Date of Birth _____

Street Address _____ SSN _____

City, State, Zip Code _____ Phone _____ BEST CONTACT

*Patients age 12–17: Guardian Name _____ Alternate Phone _____

REQUESTING PROVIDER

Provider Name _____ Back Office Phone* _____

Street Address _____ Office Fax* _____

City, State, Zip Code _____ Alternate/Cell Phone* _____

***Providing contact numbers is crucial to confirm your request**

PATIENT ELIGIBILITY

The moderate to severe immunocompromising condition that qualifies patient for Evusheld *(please check all applicable patient criteria)*:

- ☐ Active treatment for solid tumor
- ☐ Active treatment for hematologic malignancies
- ☐ Receipt of solid-organ transplant and taking immunosuppressive therapy
- ☐ Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy for it)
- ☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection (people with HIV and CD4 cell counts less than 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., greater than or equal to 20 mg prednisone or equivalent per day when administered for greater than or equal to 2 weeks)
- ☐ Active treatment with alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive
- ☐ Tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell depleting agents)
- ☐ Other immunocompromising condition: _____

OR

- ☐ The risk condition which qualifies patient for Evusheld is vaccination with COVID-19 vaccine, is associated with a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s) and thus not recommended

PATIENT IDENTIFICATION

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Other risk criteria *(please fill all that apply or leave blank if none apply)*

- ☐ BMI greater than 35 or greater than 85%ile for age
- ☐ Chronic Kidney Disease
- ☐ Diabetes
- ☐ Hypertension/Heart Disease (congenital or acquired)/Cardiovascular Disease
- ☐ Patient Age greater than 65
- ☐ Pregnancy
- ☐ Respiratory Disease
- ☐ Peds Neurodevelopmental Disorders
- ☐ Peds Medical-Related Technology/Dependence (trach, positive pressure, vent)

VACCINATION STATUS

☐ Unvaccinated or initial series not completed

☐ Initial series completed

Initial series in a person with moderate to severe immunocompromise is 3 doses of mRNA vaccine. The third dose is given 28 days after the 2nd dose. Also, a single dose of J&J qualifies as a primary series.

☐ Abbreviated H&P w/ past medical history & medication list attached

Provider Signature _____ Date _____ Virginia Medical License Number _____ Exp. Date _____

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REFERRING PROVIDER AGREEMENTS:

I, _____ *(printed name)*, the referring provider, am attesting that the patient meets ALL (A–C) of the following U.S. FDA EUA criteria to qualify for Evusheld:

A. Patient is an adult or pediatric individual who is 12 years or older weighing more than 40 kg

B. Patient is not currently infected with SARS-CoV-2 virus

C. Patient has not had a known recent* exposure to an individual with SARS-CoV-2
***recent means within 10 days of infusion**

AND

1. Moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination

☐ **Indicates Provider Agreement**

OR

2. 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 COVID-19 vaccine component(s)

☐ **Indicates Provider Agreement**

I attest that I have reviewed and provided the Fact Sheet for Patients, Parents and Medical Decision Makers Emergency Use Authorization (EUA) of EVUSHELD (tixagevimab co-packaged with cilgavimab) for Coronavirus Disease 2019 (COVID-19) document with the patient and/or their medical decision maker.

☐ **Indicates Provider Agreement**

I attest that I discussed with the patient/medical decision maker that the available monoclonal antibodies are investigational and under Emergency Use Authorization (EUA) and included aforementioned documentation in my note/EMR

☐ **Indicates Provider Agreement**

Provider Signature _____ Date _____ Virginia Medical License Number _____ Exp. Date _____

PATIENT IDENTIFICATION

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The CONSULT TO PHARMACY TO DISPENSE EVUSHELD

Injection: 300 mg/3 mL (100 mg/mL) of tixagevimab

Injection: 300 mg/3 mL (100 mg/mL) of cilgavimab

SCHED COVID-19 EVUSHELD INJECTION APPT [SCHED103]

NURSING ORDERS

- Verify with patient that they have not had a recent exposure to a person infected with COVID-19. If yes, do not proceed and notify the ordering provider.
- Monitor patients for 1 hour after administration of Evusheld.
- Staff may initiate the IP MED: ADVERSE REACTION (TREATMENT) orderset in the event of an adverse reaction.
- Place IV if signs and symptoms of reaction occur.

Provider Signature _____ Date _____ Virginia Medical License Number _____ Exp. Date _____

PATIENT IDENTIFICATION