Screening & REQUEST FORM for Evusheld™ (tixagevimab/cilgavimab)
*****SUBMISSION OF THIS REQUEST FORM IS NOT A GUARANTEE OF TREATMENT****

Instructions:
1. Licensed provider to legibly complete this form in its entirety and the consent form. **Email both forms and patient demographics/insurance information** to **Evusheld@vailhealth.org.**
2. Submission of this form is not a guarantee of treatment. If drugs are not available or the forms are not complete, this will be rejected after 48 hours and no drug will be provided. If an ordered drug is available, this form will be treated as a prescription.
3. Patient will receive a phone call with appointment date/time/location.

PATIENT INFORMATION:

NAME: _____ **DATE OF BIRTH: _____**

PHONE #: _____

ADDRESS: _____ **E-MAIL: _____**

Evusheld™ (tixagevimab/cilgavimab) is authorized for use as SARS-CoV-2 PrEP (pre-exposure prophylaxis) for adults, or pediatric individuals at least 12 years of age and >=40 kg, and who have moderate to severe immunocompromising conditions that may result in an inadequate immune response to COVID-19 vaccination or for whom vaccination with any available COVID-19 vaccine is not recommended due to a history of severe adverse reaction.

Medical conditions or treatments that may result in moderate to severe immune compromise and poor immune response to vaccination include, but are not limited to: ***(check all criteria that apply)***

- ☐ Active treatment for solid tumor and 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)
- ☐ Moderate or severe primary immunodeficiency
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids, 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: _____

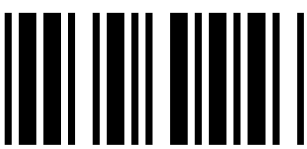
The patient must: ***(to be confirmed at time of consent and on day of injection)***

- ☐ Not be currently infected with SARS-CoV-2
- ☐ Not have had a known exposure within the past 10 days
- ☐ Not have had a COVID-19 vaccine within the past two weeks

Drug Order:

- ☐ Evusheld™ (tixagevimab 150 mg and cilgavimab 150 mg) administered as two separate intramuscular injections once. Monitor patient for at least 1 hour after injections.

  ✓ Ondansetron (Zofran) 4mg ODT PO PRN nausea
  ✓ Obtain IV access PRN
  ✓ Diphenhydramine (Benadryl) 50mg IV/IM PRN allergic reaction
  ✓ Hydrocortisone (Solu-Cortef) 100mg IV PRN allergic reaction
  ✓ Epinephrine 1mg/mL concentration 0.3mg IM PRN severe allergic reaction/anaphylaxis



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Patient Label

v1.20.2022

Provider Responsibilities and Acknowledgements

_____(Initial) Provider must review EUA FACT SHEETS for the product prescribed with the patient and discuss risks versus benefits and instruct patient to complete consent form. Please send **both** documents to Evusheld@vailhealth.org

_____(Initial) **This form will be used as a prescription order if therapy is available**. If no therapy is available, this form is void. Vail Health clinical staff may transcribe the order most appropriate for this patient.

_____(Initial) Report ALL SERIOUS ADVERSE EVENTS or MEDICATION ERRORS potentially related to ANY OF THESE AGENTS to the FDA with Form 3500 online or by contacting the FDA at 1-800-FDA-1088 to request this form.

Printed Provider Name _____ Contact Email: _____

Provider Signature _____ Date_____

Provider NPI# or DEA#: _____ Provider Cell Phone # _____