Medicine

Patient Label if Available

Order for Evusheld, Pre-exposure prophylaxis of COVID-19

Last _____ **First** _____ **DOB:** _____ **Phone:** _____
☐ Landline ☐ Cell

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient's Occupation Industry NAICS Code*: **Primary Language:**

***see Oklahoma Essential Industries List** **Weight:**

Allergies: ☐ No ☐ Yes, List: _____ **Latex Precautions:** ☐ YES ☐ No

Payor Source: ☐ Medicare ☐ Medicaid

☐ Commercial Insurance ☐ Uninsured*
*Insurance coverage nor ability to pay does NOT affect EUA criteria to receive the medication.

Name of Patient's Primary Contact: _____

Relationship: _____ **Phone:** _____
☐ Landline ☐ Cell

REQUESTS missing ANY of the ABOVE Information WILL BE RETURNED

This form does not guarantee administration. Patient selection is based on medication availability, current restrictions and the patient's weighted lottery score. Requesting provider and patient will be contacted if the patient is selected or not. Evusheld is only indicated for patients 12 years of age and older.

Service: ☐ Adult ☐ Pediatric

Administration location: ☐ Inpatient ☐ Outpatient

Has the patient been consented to receive Evusheld that has been approved for emergency use authorization (EUA) by the Food & Drug Administration (FDA) including the cardiovascular events?

☐ YES ☐ No, STOP: patient not a candidate for COVID monoclonal antibody therapy.

Is the patient currently infected with COVID-19 or has a known recent exposure to someone infected with COVID-19?

☐ YES, STOP: patient not a candidate for tixagevimab/cilgavimab ☐ No, continue to next question.

Does the patient have thrombocytopenia, coagulopathies, or other contraindications to IM injections?

☐ YES, STOP: patient not a candidate for tixagevimab/cilgavimab ☐ No

Near term mortality

Is the patient expected to die within a year from an underlying chronic, end-stage condition (not COVID-related)?

☐ YES (this will not disqualify) ☐ No, continue to next question.

Has the patient received the first, second, or booster dose of a COVID vaccine?

☐ Yes, 1st dose or second dose – counsel patient that the next dose must be delayed for 4 weeks.

Patients may still receive COVID MAB as long as the last vaccine was > 2 weeks ago and continue to next question. Date of last vaccination:

☐ Yes, booster dose – patient may still receive COVID MAB as long as the last dose was more than 2 weeks ago and continue to next question. Date of last vaccination:

☐ No, continue to next question.

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Immunosuppression: Please check all that apply

Tier 1:

- ☐ CART-Cell Therapy within the last year **OR**
- ☐ Allo/Haplo HSCT within the last year **OR**
- ☐ Auto HSCT within the last 6 months **OR**
- ☐ ALL/AML/MDS/CLL, on therapy **OR**
- ☐ Anti-CD20/52 antibody in the last year **OR**
- ☐ cGVHD on immunosuppression for less than 6 months or known/suspected lung GVHD **OR**
- ☐ Severe congenital immunodeficiency/other peds **OR**
- ☐ Solid organ transplant less than 1 year since transplant OR☐ ALL/AML not on therapy < 6 months **OR**

Tier 2:

- ☐ Solid organ transplant more than 1 year since transplant **OR**
- ☐ Other hematological malignancy on active treatment **OR**
- ☐ CVID
- ☐ HIV/AIDS (CD4 count less than 200 not on therapy)
- ☐ CML/CLL not on treatment, ALL/AML not on therapy >6 months **OR**

Tier 3:

- ☐ Other immunosuppressive condition on active therapy **OR**
- ☐ Solid tumors under active treatment

Tier 4:

- ☐ Any other immunosuppressive condition **OR**
- ☐ Vaccination not recommended due to history of severe allergic reaction to COVID-19 vaccine or vaccine component

1. Medication:
   ☒ Evusheld (tixagevimab 150 mg /cilgavimab 150 mg) IM as two separate injections preferably in the gluteal muscles

2. ☒ Monitor one (1) hour after administration for possible adverse reactions including rare cases of anaphylaxis. **Notify pharmacy of severe adverse reactions**, which must be reported to FDA Medwatch within 7 days of occurrence.

3. For an injection reaction - administer the medications below and call the Emergency Department if indicated:
   - ☒ Methylprednisolone 125 mg IV once (if IV route available)
   - ☒ Diphenhydramine 50 mg IV once. May give PO if IV route not available
   - ☒ Famotidine 20 mg IV once. May give PO if IV route not available.
   - ☒ Epinephrine 0.3 mg IM x 1 (For Anaphylaxis/throat swelling/trouble breathing)

Orders Missing Information WILL BE RETURNED.

- *There is no cost for the medication as long as national supply lasts. The Ordering Provider may need to complete prior authorization for administration when applicable.*
- *The patient will need to contact the ordering provider or primary care provider (if the requesting was from an ED Provider) for any concerns POST-MAB Infusion or return to the Emergency Department.*
- *Provider can submit the request in a Word document or in PDF format with an electronic signature.*

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Provider's Name: _____ **Provider's Location:** _____

Provider's CELL Phone: _____ **Date:** _____ **Time:** _____

Provider's Email: _____ (To communicate patient's eligibility.)

**** EMAIL Request and Documentation to** SCCPharmacist@ouhsc.edu ******