

COVID-19 Pre-Exposure Prophylaxis Order Form (EVUSHELD)

First Name: _____ Last Name: _____ Date of Birth: ____/____/_____
 Age: _____ Sex: Male Female Other Phone: _____ SSN: _____
 Height: _____ Weight: _____ Street Address: _____
 City: _____ State: _____ Zip: _____

<p>Indication - Emergency Use Authorization (non-FDA approved) for pre-exposure prophylaxis of COVID-19 in those not currently infected with SARS-CoV-2 and have not had a known recent exposure and:</p> <ul style="list-style-type: none"> ● Have moderate-severe immune compromise or ● Cannot receive a COVID-19 vaccine due to history of severe adverse reaction (e.g. allergic reaction) to a COVID-10 vaccine and/or its components
<p>Limitations of Use - Not authorized for:</p> <ul style="list-style-type: none"> ● Treatment of COVID-19 ● Post-exposure prophylaxis ● A substitute for vaccination ● Those recently vaccinated against COVID-19 (wait at least 2 weeks to administer EVUSHELD in these individuals)
<p>Important Information:</p> <ul style="list-style-type: none"> ● Patients must wait for a 1-hour observation and clinical monitoring period post administration (in case of serious hypersensitivity reaction) <p>Warnings:</p> <ul style="list-style-type: none"> ● Hypersensitivity: Possible, as with any IgG1 monoclonal antibodies ● Bleeding disorders: As with any IM injection, use caution ● Cardiovascular events: Potential risk of MI and cardiac failure
<p>Vaccination Status: _____ If vaccinated, indicate date of last vaccine: _____</p> <p>● Fully vaccinated & boosted ● Fully vaccinated but not boosted ● Partially vaccinated ● Unvaccinated</p>
<p>Inclusion Criteria I - The patient must meet ALL of the following:</p> <ul style="list-style-type: none"> ● 12+ years of age and weighing at least 40 kg ● Not currently infected with SARS-CoV-2 ● Have not had a known recent exposure
<p>Inclusion Criteria II - The patient must meet ONE of the following:</p> <ul style="list-style-type: none"> ● Have moderate-severe immune compromise (due to a medical condition such as active cancer/advanced or untreated HIV/solid organ transplant or receipt of immunosuppressive medications or treatments) ● Cannot receive a COVID-19 vaccine due to history of severe adverse reaction (e.g. allergic reaction) to a COVID-10 vaccine and/or its components

Medication Order:

<input type="checkbox"/> EVUSHELD - Tixagevimab 300mg/3mL & Cilgavimab 300mg/3mL (two separate, consecutive IM injections)	
_____ Prescriber Name	_____ Prescriber Signature
_____ Date	_____ Time