OH REFERRAL FOR EVUSHELD (AZD7442)

(This is a long-acting prophylactic monoclonal antibody reserved for vaccinated adults and pediatric patients [12 years of age and older weighing at least 40 kg] who are immunocompromised. This therapy is restricted to those meeting very specific qualifications.)

Patient Name: _____ Patient's Age _____

Patient's DOB: _____ Patient's Contact Number: _____

***All Questions Must be Answered before Order is Valid* Fax Completed Form to 270-688-2275**

Is the patient an adult or a pediatric patient who is ≥ 12 years and weighs ≥ 40 kg? Yes or No
(If no, the patient does not qualify.)

Is the patient positive for COVID-19 or had known recent exposure to COVID-19? Yes or No
(If yes, the patient does not qualify. Consider Treatment with alternative COVID monoclonal antibodies.)

Has the patient been vaccinated for COVID-19? Yes or No
(Must be vaccinated to qualify based on state requirement)

EUA Dosing Changes (Evusheld EUA)

- ***Due to decreased neutralization activity of Evusheld against the omicron subvariants the initial dose of Evusheld in adults and pediatric individuals (12 years of age and older at least 40 kg) is 300 mg of tixagevimab and 300 mg of cilgavimab administered as two separate consecutive IM injections.***
- ***Repeat doses may occur every 6 months at 300 mg of tixagevimab and 300 mg of cilgavimab administered as two separate consecutive IM injections***
- ***Individuals who already received the originally approved dose of 150 mg of tixagevimab and 150 mg of cilgavimab should receive a second Evusheld dose of 150 mg of tixagevimab and 150 mg of cilgavimab as soon as possible. If needed please contact the pharmacy at 270-417-6700.***

Select Dose:

☐ Initial dose: 300 mg of tixagevimab and 300 mg of cilgavimab (2 separate 3 ml, IM injections)

☐ Follow up Dose: 300 mg of tixagevimab and 300 mg of cilgavimab (2 separate 3 ml, IM injections)
[should be 6 months or more from previous dose]

Indications for use: (Check all that apply)

☐ Active treatment for solid tumor or hematologic malignancy

☐ 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 (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)

☐ Advanced or untreated HIV infection (people with HIV and CD4 cell counts < 200/mm^3, 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, 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)

Has the Patient and/or Caregiver received "Fact Sheet" information in written or verbal form? Yes or No

Has Patient been informed of alternatives to receiving a monoclonal antibody? Yes or No

Has the Patient been informed that monoclonal antibodies are an unapproved drug that is authorized for use under the Emergency Use Authorization? Yes or No

Provider Printed Name: _____

Provider Signature: _____

By signing above you are confirming the accuracy of the information presented above.