NOVELLO INFUSION

Evusheld Order Form

Patient Name: _____ **Patient DOB:** _____

Patient Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Patient Email: _____ **Patient Phone:** _____

Patient Allergies: _____

If vaccinated for COVID-19, date of last vaccination ***(Evusheld must be 2 weeks after vaccination)*****:** _____

Evusheld Emergency Use Authorization (EUA) Criteria:

The EUA is for the use of the unapproved product Evusheld for the pre-exposure prophylaxis of COVID- 19 in adults and pedatric patients who meet the inclusion criteria below:

Inclusion criteria (all must be true to qualify for therapy):

- ⬭ Patient ≥ 12 years old
- ⬭ Patient ≥ 40 kg
- ⬭ Patient not currently infected with COVID-19
- ⬭ No known recent exposure to COVID-19

And one of the following:

- ⬭ 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 as defined below:
  - ⬭ Active treatment for solid tumor and hematologic malignancies
  - ⬭ Receipt of solid-organ transplant and taking immunosuppressive therapy
  - ⬭ Receipt of chimeric antigen receptor-T-cell or hematopoietic stem cell transplant (within last 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 count <200/mm3, history of an AIDS-defining illness without immune reconstitution or clinical manifestation 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, TNF blockers, and other biologic agents that are immunosuppressive immunomodulator (e.g., B-cell depleting agents)

- ⬭ Vaccination with any available COVID-19 vaccine is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine or component

Consent Statement:

⬭ As the patient's healthcare provider, I have communicated to the patient or parent/caregiver listed above, as age appropriate, the information consistent with the "Fact Sheet for Patients, Parents and Caregivers" prior to the patient receiving Evusheld. I have documented in the patient's medical record that the patient/caregiver has been:

1. Given the "Fact Sheet for Patients, Parents and Caregivers". The fact sheet can be accessed at: https://www.fda.gov/media/154702/download
2. Informed of alternatives to receiving Evusheld, and
3. Informed that Evusheld is an unapproved drug that is authorized for use under Emergency Use Authorizations.

Drug/Nursing Orders:

⬭ Evusheld (tixagevimab 300 mg and cilgavimab 300mg) IM once (as two separate consecutive injections in two separate injection sites). Observe for 1 hour following injection, and then discharge. Treat any allergic or infusion reactions per protocol.
"Emergency medications and treatment per Novello Infusion policy."

Provider Signature: _____ **Date:** _____ **Time:** _____

Provider Printed Name: _____ **NPI #** _____

Provider Phone #: _____ **Provider Fax #:** _____

ONCE COMPLETED, PLEASE FAX TO Novello Infusion 231-600-7058