

# EVUSHELD REFERRAL FORM

## PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Social Security #	Primary Language
Address		
City	State	ZIP
Allergies		
Phone	Height	Weight
ICD-10 Code <input type="checkbox"/> Code _____ Qualifying diagnosis <input type="checkbox"/> U09.9 Post-Covid condition unspecified		

## PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	Referral Contact Email	
Office Phone	Office Fax	
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		

## INSURANCE INFORMATION

Insurance Provider	Plan ID #	Eligible for Medicare (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	List Red, White & Blue Card #
Insured's Name	Relationship to Patient	If no insurance, list driver's license number and state of issue	

**Please fax with order form: Current Medication List & Copy of Insurance Card**

## ELIGIBILITY

**Exclusion Criteria:** EVUSHELD is not authorized for use in individuals:

- For treatment of COVID-19
- For post-exposure prophylaxis of COVID-19 in individuals who have been exposed to someone infected with SARS-CoV-2
- Pre-exposure prophylaxis with EVUSHELD is not a substitute for vaccination in individuals for whom COVID-19 vaccination is recommended. Individuals for whom COVID-19 vaccination is recommended, including individuals with moderate to severe immune compromise who may derive benefit from COVID-19 vaccination, should receive COVID-19 vaccination.
- In individuals who have received a COVID-19 vaccine, EVUSHELD should be administered at least two weeks after vaccination.

**Inclusion Criteria:** Check all that apply

For the pre-exposure prophylaxis of COVID-19 in adults and pediatric individuals (12 years of age and older weighing at least 40 kg):

Who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to an individual infected with SARSCoV-2 and:

Who have moderate to severe immune compromise due to a medical condition such as cancer, untreated HIV, etc.. (not a complete list, see EUA for more)

Who receive immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination.

## MEDICATION ORDERS

**\*EVUSHELD may only be prescribed for an individual patient by physicians, advanced practice registered nurses, and physician assistants that are licensed or authorized under state law to prescribe drugs in the therapeutic class to which EVUSHELD belongs (i.e., anti-infectives) Standing orders may not be used per the EUA.**

**\*EVUSHELD New One Time Dose:** EVUSHELD once 300mg tixagevimab IM and 300mg cilgavimab IM as separate IM injections

**\*EVUSHELD Previous 150mg/150mg Dose:** Additional EVUSHELD one time 150mg tixagevimab IM and 150mg cilgavimab IM as separate IM injections.

**Anaphylaxis Kit** per Amber Specialty Pharmacy Home Infusion anaphylaxis treatment protocol.

### Indicate vaccination status:

Unvaccinated    Partially Vaccinated    Fully Vaccinated    Boosted

## Nursing Orders

Administer IM in two injections, Monitor patient for one hour post injection, follow Anaphylaxis protocol if necessary.

**Phone: 855.896.9254**  
**Fax: 855.370.0086**

## SIGNATURE

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
NPI