Evusheld® (Tixagevimab and Cilgavimab) Referral
Form Meritus Medical Center (version 5.6.22)

Please fax completed form to 301-665-4675. Please review consent and facts sheet with patient prior to faxing.

Patient Name (First and Last): **DOB:** **Age:**

Gender (circle one): Male Female Other/Unknown

Patient preferred contact number: **County of residence:** **Zip code:**

Patient preferred language (circle one): English Spanish Other:_____

EMERGENCY USE AUTHORIZATION:
The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) for the emergency use of the unapproved product EVUSHELD (tixagevimab co-packaged with cilgavimab) for the pre-exposure prophylaxis of coronavirus disease 2019 (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 SARS-CoV-2 and
    - Who have 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 or
    - For whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s).
    - Patients who received a COVID-19 Vaccine should not receive Evusheld within 2 weeks of vaccine administration.

Medical conditions or treatments that may result in moderate to severe immune compromise and an inadequate immune response to COVID-19 vaccination include but are not limited to:

- Active treatment for solid tumor and hematologic malignancies
- 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)

Meritus Medical Center may have further criteria for use depending on scarcity of medication supply.

Patient's Diagnosis: Pre-Exposure Prophylaxis of COVID-19 Secondary "at risk" Diagnosis _____

☐ **Order: Administer Evusheld (Tixagevimab 300 mg and Cilgavimab 300 mg) IM x 1 dose (2 injections = 1 dose)**

I, the referring provider, have read and understand the EUA information above. I have advised the patient on the benefits and possible adverse reactions as stated in the EUA.

**** ☐ Indicates Provider Agreement (please check box)** **Provider NPI #** _____

Provider name (print):_____ **Date:** _____

Provider signature:_____ **Phone number:** _____

MERITUS MEDICAL CENTER

Informed Consent for Evusheld Injection

Patient Name:				Date:	
Date of Birth:		Age:		MRN:	

I understand that I have been referred by an authorized, licensed prescriber to receive Evusheld (Tixagevimab and Cilgavimab). The Food and Drug Administration (FDA) has issued an emergency use authorization (EUA) for this injection. Evusheld is for pre-exposure prevention of COVID-19 infection in adults and pediatric individuals (12 years of age and older weighing at least 40 kg) at high risk for severe disease and who are unable to receive a COVID-19 vaccine.

It has been explained to me that I am eligible to receive Evusheld under the FDA's EUAs.

1. I understand that the FDA has authorized emergency use of Evusheld for the purposes of preventing COVID-19 infection.
2. I understand that consent for this treatment is voluntary. I have the option to accept or refuse administration of Evusheld, including the option to refuse the injection.
3. I have been given a copy of the applicable FDA's Fact Sheet for Patients and Parents/Caregivers and have been given the opportunity to discuss it with my provider.
4. I have been informed of the potential risks and benefits of Evusheld and the extent to which such risks and benefits are unknown.
5. I have been informed of any available alternative treatments and the risks and benefits of those alternatives.
6. I understand that if I have received a COVID-19 vaccine that I should not receive Evusheld until 2 weeks after I received the vaccine.
7. I have been informed that Evusheld is not guaranteed to prevent me from getting COVID-19 and that I should still follow all other safety measures to prevent infection.

Before signing:

- **Carefully read this form and the FDA's Fact Sheet for Patients and Parents/Caregivers or have them read to you.**
- **Listen to your healthcare clinician explain the treatment to you.**
- **Please ask questions about anything that is not clear.**

By signing below, I certify that I have read and understand the information provided to me and consent to receive Evusheld. I hereby authorize Meritus Medical Center and its agents to administer Evusheld and to perform such additional procedures as are considered necessary to monitor and provide care for the duration of this treatment course.

Printed Patient Name: _____

Patient or Authorized Representative Signature: _____ Date: _____