SIBLEY MEMORIAL HOSPITAL- JOHNS HOPKINS MEDICINE

EVUSHELD ORDER FORM FOR PRE-EXPOSURE PROPHYLAXIS
(complete all sections legibly)

Date &Time_____ Patient Name_____

DOB_____ Phone number _____

Allergy: _____ Address: _____

Name and phone number of nearest relative _____

Previously admitted to SMH or JHHS entity: ____Yes ____No ____Unknown

_____ Outpatient request _____ Inpatient request (SM#_____)

Evusheld (tixagevimab and cilgavimab) is available to patients who meet emergency use authorization (EUA) criteria.

- If the requesting provider is a **Sibley-based oncologist or Community-based oncologist privileged at Sibley,** he/she/they enters the order directly into Epic/Beacon. No pre-screening by clinical pharmacist or paper order form submission required.

- If the requesting provider is a **non-oncologist privileged at Sibley**, he/she/they must complete this form, and email via secure email to the SMHEvusheldAdmin@jhmi.edu OR fax to pharmacy department at (202) 537-0072 followed by phone call at (202) 537-4171. The Infusion Center clinical pharmacist will review then enter the order into Epic/Beacon within 72 hours of receipt of request.

Patient will be scheduled on a daily basis excluding weekends and holidays. Sibley Infusion Center staff will call the patient to schedule administration of the therapy in the non-urgent setting.
Please note Evusheld (tixagevimab and cilgavimab) supply and staffing resources may be limited and can impact the number of patients we are able to treat.

Clinical Criteria and Data Requirements for Patient: (Must complete each item as appropriate)

- Weight of patient is >/= 40Kg : ____ Yes ____ No; if no, note the patient's weight _____
- Received prior infusion of monoclonal antibodies for COVID-19 infection: _____ Yes ____No; If yes, please indicate the name and when received _____
- Received or scheduled to receive COVID-19 vaccination _____ Yes ____No; if yes, when _____
  if received, Evusheld should be administered at least 2 weeks after vaccination
- Prior COVID-19 infection: _____ Yes (if yes, when_____) ____ No
- I confirm Evusheld is authorized for use in patients: _____ Yes ____ No
  - Patients must NOT be currently infected or having symptoms with COVID-19 **AND**
  - Patients must not have had a known recent exposure (within 14 days) to an individual infected with COVID-19.
  - Additionally, patients must fall into one of the two categories below to qualify for treatment:
    - ☐ Patients with moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications for treatment, and who may not mount an adequate immune response to COVID-19 vaccination. Please specify_____
      OR
    - ☐ Patients in 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 COVID19 vaccine component(s).

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Dosing:

_____ Initial Dosing: Tixagevimab 300 mg and cilgavimab 300 mg as a single dose

_____ Repeat Dosing: For patients who initially received tixagevimab 150 mg and cilgavimab 150 mg (previously approved dose)

- ☐ If initial dose was ≤3 months ago: administer a follow-up dose of tixagevimab 150 mg and cilgavimab 150 mg
- ☐ If initial dose was >3 months ago: administer tixagevimab 300 mg and cilgavimab 300 mg

_____M.D (____)_____

Signature Cell Number (used for notifying of decisions and questions)

_____

Please Print Name

For Pharmacy/Antimicrobial Stewardship Team Use

_____ RPh Date/Time_____

Pharmacy phone number: 202-537-4171

Updated: 7/19/22