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**Bird’s Eye Medical COVID-19 Monoclonal Antibody (mAb) EUA Treatment Referral**: **EVUSHELD**

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| **Patient Information** | |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M / F Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Weight/BMI if high risk factor: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **NOTE: For patients with moderate to severely compromised immune systems and not currently infected with COVID-19.** This product is available for use by Emergency Use Authorization (EUA) as pre-exposure prevention of COVID-19 for up to six months in people 12 years of age and older weighing at least 40 kg who are not currently infected with COVID-19 and who have had no known recent exposure to COVID-19 **and** have moderate to severely compromised immune systems due to a medical condition or immunosuppressive medications or treatments **and** may not mount an adequate immune response to COVID-19 vaccination **or** a history of severe adverse reactions to a COVID-19 vaccine and/or component(s) of those vaccines. This product is NOT a substitute for vaccination, nor authorized for the treatment of COVID-19 or for post-exposure prevention of COVID-19.  **NOTE on EVUSHELD dosing:** The FDA updated dosing guidelines of EVUSHELD from 150 mg each of tixagevimab and cilgavimab to 300 mg of each medication on 2/24/22. Per the updated guidance 6/2022, a complete dose of 300 mg each of tixagevimab and cilgavimab should be administered every 6 months. For those who received two separate doses of 150 mg of each medication, redosing should be 6 months after the last dose. | |
| **Treatment Criteria for Use** (all fields must be completed to be eligible for treatment) | |
| **Treatment-qualifying high-risk condition(s):**   |  | | --- | | * 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 count <200mm3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV) | | * Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent/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) | | * Other medical conditions or factors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (see CDC website for considerations) | | |
| **Monoclonal Antibody Order:** | |
| * **Repeat dosing;** **previous dose 6 months prior:** Tixagevimab 300 mg IM and Cilgavimab 300 mg IM   + **Date of last dose:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *please provide documentation of previous dose* * **First time dosing (all new EVUSHELD patients):** Tixagevimab 300mg IM and Cilgavimab 300 mg IM | |
| **Prescriber Attestation** | |
| **I affirm that my patient meets above criteria for use and has been:**   1. Informed that this mAb is an unapproved drug authorized for use under an **Emergency Use Authorization.** 2. Informed of alternatives to receiving EVUSHELD. 3. I have discussed this treatment option with the patient and patient is agreeable to this treatment. | **I am aware that:**   1. EVUSHELD will be administered as a two separate, consecutive ventrogluteal IM injections. Patient will be monitored in the clinic for 1 hour post administration. Standard hypersensitivity reaction therapy will be provided as needed. |
| Signature signifies agreement of the above orders / attestation.  Provider Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ After hours phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| The prescribing health care provider and/or provider’s designee should complete and submit a MedWatch form to FDA within 7 calendar days from the onset of a serious and unexpected adverse event that appears to be associated with the use of a monoclonal antibody. | |

PLEASE FAX this form to **360.878.8330**. **If this is a repeat dose,** **send documentation of prior administration.**

*If possible, attach copy of problem list, allergies, and medications.*

**Bird’s Eye Medical will reach out to schedule your patient ASAP. For questions, please call 360-688-7044.**