EVUSHELD ORDER FORM

***** Medication is on Emergency Use Authorization (EUA) and is in limited supply*****

Patient Name:_____ **Date of Birth:** _____

Date of Last COVID-19 Vaccine or Booster: _____ **(Must be 2 weeks prior)**

I authorize the following to be given based on medication availability:

☐ **Evusheld: Tixagevimab 150 mg in combination with Cilgavimab 150 mg IM x 1**

☐ **Rapid Covid (SARS-CoV-2 RNA Rapid) Lab Test**

Inclusion Criteria :

☐ **No Cardiac Risk Factors/History of Cardiovascular Disease (Not including Hypertension)**

☐ **No Thrombocytopenia or any coagulation disorder**

Provider Name (Print):_____ Date:_____

Provider Signature :_____

*****Adult/Pediatric (12 years of age and older weighing at least 40 kg) patient must meet required at least one high-risk criteria along with a NEGATIVE SARS-CoV-2 test result*****

☐ ≥ 65 or older	☐ Chronic Kidney Disease
☐ Hypertension	☐ Pregnant Women and women 6 or less weeks post partum
☐ Diabetes	☐ Sickle cell Anemia
☐ Immunosuppressive Disease or Immunosuppressive treatment	☐ Obesity/Overweight (BMI ≥35 KG/M^2)
☐ Neurodevelopment disorder (example: cerebral palsy) or other conditions that confer medical complexity (example: genertic or metabolic syndromes and severe congenital abnormalities	☐ Medical related technological dependance (not related to COVID-19) Examples: tracheostomy, gastrostomy, or positive pressure ventilation
☐ Chronic Lung Disease: COPD, asthma, interstitial lung disease, cystic fibrosis, or pulmonary hypertension	

Please Fax this order form along with the following information to 317-398-1827:

1. **Copy of NEGATIVE Covid test result (must be obtained day of administration)**
2. **Patient demographic sheet**
3. **Copy of Vaccine Record**