Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Evusheld (Cilgavimab & Tixagevimab) Order Form

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

***Please briefly indicate the clinical rationale for Evusheld (i.e. disease state/drug that puts patient at risk):**

_____

***Please *make sure* the ordering provider signs the Patient Consent form attached to this order.**
If need be, we will permit the patient to complete the form by physically signing the consent at the time of administration of Evusheld.

Evusheld Dosing – Standard for all patients:

- Dose is divided into two individual antibody components (cilgavimab and tixagevimab): each 300mg/3mL
- Dose is administered as two individual intramuscular injections:
  - One given in each gluteal muscle
- Patient will be observed for one hour after injection

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name: _____
Provider Signature: _____ Date: _____
Phone: _____ Fax: _____ Pager: _____

New England Cancer Specialists: Informed Consent
Evusheld (tixagevimab and cilgavimab) for pre-exposure prophylaxis of coronavirus

Patient's Name: _____ **Patient's DOB**: _____
I hereby certify that I have explained the risks, benefits, alternatives, and possible modes of treatment to this patient. We have jointly arrived at the decision to proceed with the administration of tixagevimab and cilgavimab which is currently authorized for emergency use (EUA) by the Food & Drug Administration (FDA).
Physician Name:_____
Date: _____ **Time**: _____

I, the undersigned, hereby authorize New England Cancer Specialists to administer Evusheld (tixagevimab and cilgavimab) a monoclonal antibody combination for the purpose of preventing COVID 19 infections.

- The U.S. Food and Drug Administration has issued an EUA for the emergency use of the unapproved product EVUSHELD (tixagevimab co-packaged with cilgavimab), SARS-CoV-2 spike protein-directed attachment inhibitor, 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 SARSCoV-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 COVID19 vaccine component(s).

I hereby certify that Dr. _____ has answered all my questions and explained to me the reasons why use of the above named medication is considered desirable or necessary. Some of the known risks of these medications explained to me include, but are not limited to: Hypersensitivity reaction, injection site bleeding/bruising, cardiovascular events, headache, fatigue, and cough.
These can happen during and after the infusion and should be reported to my healthcare provider right away. These are not all the possible side effects. Serious and unexpected side effects may happen. Tixagevimab and cilgavimab is still under investigation. Therefore, there may be risks, side effects, and/or long-term effects that are related to this treatment but are unknown at this time. I have been advised of risks and possible benefits. This treatment has been carefully explained to me. Additional printed material specific to my drug therapy has been reviewed and given to me. I received and reviewed the FACT SHEET FOR HEALTHCARE PROVIDERS: EMERGENCY USE AUTHORIZATION FOR EVUSHELD™ (tixagevimab co-packaged with cilgavimab). This permission is based on knowledge and understanding of the elements of the therapy and an awareness of the risks, consequences, and discomforts.
I, the undersigned, hereby consent to proceed with the use of this medication.

Patient / Representative Signature _____

Date:_____ **Time**: _____

Relationship to Patient (if representative signature): _____

Physician Signature: _____

Date: _____ **Time**: _____