Physician Order Form Instructions for COVID-19 Antiviral Therapy

Evusheld (tixagevimab and cilgavimab) intramuscular injection

Step 1: After assessing patient's eligibility, electronically send the Rx to Kohll's Rx. (12741 Q Street Omaha, NE 68137) (NPI: 1811462856) If unable to send electronically, the form below may be faxed to 888-972-4110. Please also send a copy of the patient's pharmacy insurance card.

Step 2: The medication will be administered by appointment only

Indication: Emergency Use Authorization (non-FDA approved) for pre-exposure prophylaxis of coronavirus disease (COVID-19) in adults and pediatric patients

Inclusion Criteria	Exclusion Criteria
The patient must meet all of the criteria below to be eligible. Please circle the applicable criteria this patient meets: • Age >12 years • Weight > 40kg • **Patient has 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 **AND** • Not currently infected with SARS-CoV-2 and the patient has not had a known recent exposure to an individual infected with SARSCoV-2 **OR** • Vaccination of COVID-19 vaccine, is not recommended due to a history of severe adverse reaction to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s) • Patient received their COVID-19 vaccine (if eligible) >2 weeks prior	EVUSHELD is <u>not</u> authorized for use in patients: • For treatment of COVID-19 • For post-exposure prophylaxis of COVID-19 in individuals who have been exposed to someone infected with SARS-CoV-2. • Pre-exposure prophylaxis with EVUSHELD is not a substitute for vaccination in individuals for whom COVID-19 vaccination is recommended. • Received their COVID-19 vaccine <2 weeks prior • Has not previously received Evusheld within the last 3 months • Patients with a history of cardiovascular disease

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PATIENT DEMOGRAPHICS

Patient Name (Last, First, MI):_____Date of Birth: _____

Sex:_____Weight:_____lb Height:_____in Phone Number: _____

Address:_____SSN: _____

DIAGNOSIS

_____ Date of most recent COVID-19 vaccine _____Not eligible for COVID-19 vaccine

_____Patient is currently COVID-19 (-), is not experiencing signs and symptoms of COVID-19, and has not been exposed to a COVID + individual within the last 2 weeks

_____No, patient has never received Evusheld previously
_____Yes, patient received Evusheld previously on_____(mm/dd/yyyy)

PRESCRIPTION

_____ Initial dose: 300 mg of tixagevimab and 300 mg of cilgavimab administered as two separate consecutive intramuscular injections

_____ Second dose, 3 months post-initial dose: 150 mg tixagevimab and 150 mg cilgavimab administered as two separate consecutive intramuscular injections

IF THE ABOVE LINES ARE NOT CONFIRMED , WE WILL NOT DISPENSE THE PRODUCT

Provider Full Name:_____NPI:_____

Address:_____

Office Phone:_____Office Fax:_____Contact Name: _____

Prescriber Signature:_____ Date: _____

FAX: **888-972-4110**