EVUSHELD
REFERRAL FORM

AMBER™ SPECIALTY PHARMACY

PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Social Security #	Primary Language
Address		
City	State	ZIP
Allergies		
Phone	Height	Weight
ICD-10 Code ☐ Code _____ Qualifying diagnosis ☐ U09.9 Post-Covid condition unspecified		

PRESCRIBER INFORMATION

Name of Contact Sending Referral		Title
Preferred Contact Method (check one)	☐ Email ☐ Phone ☐ Fax	Referral Contact Email
Office Phone		Office Fax
Practice / Facility Name		
Address		
City	State	ZIP
Prescriber Name / Specialty		

INSURANCE INFORMATION

Insurance Provider	Plan ID #
Insured's Name	Relationship to Patient

Eligible for Medicare (check one)	☐ Yes ☐ No	List Red, White & Blue Card #
If no insurance, list driver's license number and state of issue		

Please fax with order form: Current Medication List & Copy of Insurance Card

ELIGIBILITY

Exclusion Criteria: EVUSHELD is not authorized for use in individuals:

- 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. Individuals for whom COVID-19 vaccination is recommended, including individuals with moderate to severe immune compromise who may derive benefit from COVID-19 vaccination, should receive COVID-19 vaccination.
- In individuals who have received a COVID-19 vaccine, EVUSHELD should be administered at least two weeks after vaccination.

Inclusion Criteria: Check all that apply

☐ For the pre-exposure prophylaxis of 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 such as cancer, untreated HIV, etc.. (not a complete list, see EUA for more)
- ☐ Who receive immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination.

MEDICATION ORDERS

***EVUSHELD may only be prescribed for an individual patient by physicians, advanced practice registered nurses, and physician assistants that are licensed or authorized under state law to prescribe drugs in the therapeutic class to which EVUSHELD belongs (i.e., antiinfectives) Standing orders may not be used per the EUA.**

☐ ***EVUSHELD New One Time Dose:** EVUSHELD once 300mg tixagevimab IM and 300mg cilgavimab IM as separate IM injections

☐ ***EVUSHELD Previous 150mg/150mg Dose:** Additional EVUSHELD one time 150mg tixagevimab IM and 150mg cilgavimab IM as separate IM injections. If patient has received 150mg equal to or less than 90 days previously they should receive an additional 150mg/150mg dose

☒ **Anaphylaxis Kit** per Amber Specialty Pharmacy Home Infusion anaphylaxis treatment protocol.

Indicate vaccination status:

☐ Unvaccinated ☐ Partially Vaccinated ☐ Fully Vaccinated ☐ Boosted

Nursing Orders

Administer IM in two injections, Monitor patient for one hour post injection, follow Anaphylaxis protocol if necessary.

SIGNATURE

_____ _____

Prescriber Signature Date

_____ _____

Please Print Name NPI

Phone: 855.896.9254
Fax: 855.370.0086

REV.06.13.22

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