

## Specialty Order Form

Patient: _____	Ordering Provider: _____
DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ lbs.	NPI: _____
Height: _____ ICD-10 Code(s): _____	Practice: _____
Diagnosis: _____	Phone: _____
Allergies: _____	Fax: _____
Primary Care Provider: _____	Contact Name: _____

Please indicate which dose is to be administered by checking the boxes below. If none are indicated no medication will be administered.

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**Evusheld** Tixagevimab 300mg and Cilgavimab 300mg via IM Injection.

Initial Dose x1

Maintenance Dose (6 months after initial dose) x1

**PRN-Medication(s):**

- Acetaminophen/Tylenol: 650 mg PO x1
- Diphenhydramine/Benadryl: 25 mg IV or PO x1
- Ondansetron/Zofran: 4 mg IVP x1

**Quick Checklist for mAb patients.**

- I have discussed the EUA requirements and reviewed the fact sheet for the patients, parents or caregiver.
- Patient has not received COVID-19 vaccine within the last 14 days
- The patient has given verbal consent to receive Evusheld.
- Include demographic sheet and if applicable a copy of the insurance card(s).
- Completed Cascade ID & Infusion Specialty Order Form.
- Patient does not currently have COVID-19 and has no known recent exposure

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_