THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Emergency Use Authorization (EUA) Cilgavimab/Tixagevimab: **RESTRICTED USE** For COVID-19

Patient Label

Describe Drug Allergies and Reactions: _____

Cilgavimab/tixagevimab may be used in patients for pre-exposure prophylaxis for SARS-CoV-2 infection.

They must meet the following criteria:

1. ≥ 12 years of age
2. Weight ≥ 40 kg
3. Not currently infected with SARS-CoV-2 and have not had a known, recent exposure to an individual infected with SARS-CoV-2 **AND**
    a. Has 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**
    b. Vaccination with any available COVID-19 vaccine is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine and/or its components

[1]Severe immune compromising conditions:
- Patients within 1 year of receiving T- or B-cell depleting agents (e.g., rituximab, ocrelizumab, ofatumumab, alemtuzumab, belatacept, anti-thymocyte globulin)
- Patients receiving Bruton tyrosine kinase inhibitors
- Post-hematopoietic cell transplant patients with chronic graft versus host disease or are taking immunosuppressive medications for another condition
- Patient with hematologic malignancies on active treatment
- Lung transplant recipients
- Patients who are within 1 year of receiving a solid-organ transplant (other than lung transplant)
- Solid-organ transplant recipients with recent treatment (previous 1 year) for acute rejection with T- or B-cell depleting agents
- Severe combined immunodeficiencies
- Advanced or untreated HIV with a CD4 cell count < 50 cells/mm^3

Authorized Indication (Select one):

___ Pre-exposure prophylaxis for SARS-CoV-2 Infection per EUA Criteria

____ **Initial Dose:** for patients who have never received a dose of Evusheld®
- Cilgavimab 300mg/3mL IM injection + tixagevimab 300mg/3mL IM injection

____ **Second Dose:** for patients who have received ONE dose of Evusheld® 150mg/150mg **less than or equal to 3 months ago**
- Cilgavimab 150mg/1.5mL IM injection + tixagevimab 150mg/1.5mL IM injection
  Date of first dose ____/____/____ (MUST HAVE ONE DOCUMENTED DOSE)

____ **Second Dose:** for patients who have received ONE dose of Evusheld® 150mg/150mg **greater than 3 months ago**
- Cilgavimab 300mg/3mL IM injection + tixagevimab 300mg/3mL IM injection
  Date of first dose ____/____/____ (MUST HAVE ONE DOCUMENTED DOSE)

**One dose of Evusheld® is defined as 150mg/1.5 mL of cilgavimab + 150 mg/1.5 mL of tixagevimab (one "kit") Complete prophylaxis is defined as two total doses (kits) of Evusheld® (300 mg/3mL cilgavimab+300 mg/3mL tixagevimab*

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Emergency Use Authorization (EUA)
Cilgavimab/Tixagevimab:
RESTRICTED USE
For COVID-19
Outpatient ORDER

Patient Label

____ **Repeat Dose:** Every 6 months for patients who have received Evusheld® initial dose (300mg/300mg) **OR** previously authorized initial dose (150mg/150mg) followed by second dose

- Cilgavimab 300mg/3mL IM injection + tixagevimab 300mg/3mL IM injection
  Date of most recent dose ____/____/____

Administration instructions:

Administer the IM injections at different injection sites, preferably one in each of the gluteal muscles, one after the other. For the 300 mg tixagevimab and 300 mg cilgavimab dose, ensure that the administration sites are appropriate for the volume (3 mL per injection)

RN Message: *Monitor for anaphylaxis and other hypersensitivity reactions, such as fever, chills, hypotension, angioedema, arrhythmia, and rash. Contact physician if these adverse effects occur.*

1. Set patient up for clinical monitoring after injection for observation.

2. Monitor after injection and observe for at least 1 hour after injection is complete.

By submitting this order, I confirm that the patient or caregiver received a copy of document and agreed to Cilgavimab/Tixagevimab under "Fact Sheet for Patients, Parents, and Caregivers Emergency Use Authorization (EUA) of Cilgavimab/Tixagevimab for Coronavirus Disease 2019 (COVID-19)." I confirm that documentation of this discussion is in the patient's medical record.

Prescriber Signature Date

Printed Name Contact Number for Questions

Order Set Version Date: 6/30/2022