ACCOUNT #	DOB	**FREDERICK HEALTH**
UNIT #	AGE	**400 West 7th Street**
ADMIT DATE	SEX	**Frederick, MD 21701**
		240-566-3300

Frederick Health

Evusheld for Pre-exposure Prophylaxis Against COVID-19

Please complete the information on this form if your patient could benefit from pre-exposure prophylaxis using Evusheld. This form should be faxed to the Frederick Health Referral Fax line at 240-566-3959.

*******Please provide the last office note to prevent delays in treatment*******

First Name:_____ Last Name:_____

DOB: _____ Age: _____

Sex: ☐ M ☐ F ☐ Other_____ ☐ Unknown

Patient's Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Address Line 1:_____

Address Line 2:_____

City:_____ State: _____ County:_____ **Zip:_____

Phone: ☐ cell ☐ home Secondary Phone: ☐ cell ☐ home

Allergies (medication/food/other): _____

_____

Please include any additional historical patient health information. You may free text, copy/paste, or you may attach a recent clinic note or other documentation, as necessary.

Has the patient been exposed to a person infected with COVID-19 in the past 10 days?

☐ Yes ☐ No

Is the patient currently infected with COVID-19?

☐ Yes ☐ No

Vaccination Status:

☐ Vaccinated ☐ Vaccinated + Boosted ☐ Not Vaccinated

Date of last vaccine dose _____

Please select the appropriate indication for Evusheld therapy

**Currently, Evusheld is allocated by the federal government and Frederick Health has a limited supply. Patients will be provided therapy based on the current inventory level. If a situation arises in which there is not enough drug to treat all requests a risk stratification process will be employed. Once additional doses are obtained, patients will be treated based on risk and the order in which referrals are received.*

FREDERICK HEALTH

400 West 7th Street
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240-566-3300

Frederick Health

Evusheld for Pre-exposure Prophylaxis Against COVID-19 (continued)

☐ Active treatment for solid tumor and hematologic malignancies

- o Tier one:
  - Allogeneic Stem Cell transplants (in past 6 months)
  - CAR-T in the past six months
  - Active GVHD requiring therapy
  - Active treatment for lymphoid malignancies (CLL and myeloma will be given priority over other lymphoid malignancies)
- o Tier two:
  - Other heme malignancy patients on active treatment
- o Tier three:
  - Other active-treatment Cancer Patients

☐ Receipt of solid-organ transplant and taking immunosuppressive therapy

- o Tier one:
  - Lymphocyte depleting therapy (ie. ATG, alemtuzumab, rituximab) within previous 6 months AND unable to complete the vaccine series* due to medical reasons
  - Lymphocyte depleting therapy (ie. ATG, alemtuzumab, rituximab) or plasmapheresis within previous 6 months AND DOES NOT have antibody response despite completing COVID-19 vaccine series
  - Lung transplant recipient that has completed vaccine series AND DOES NOT have antibody response following 3rd dose (or booster) of COVID-19 vaccine
  - Any transplant recipient that has completed vaccine series AND DOES NOT have antibody response following 3rd dose (or booster) of COVID-19 vaccine AND lives in a congregate setting setting (i.e., nursing home, assisted living facility, etc.)
- o Tier two:
  - Age >65, completed vaccine series AND DOES NOT have antibody response following 3rd dose (or booster) of COVID-19 vaccine
- o Tier three:
  - Age <65 (non-lung transplant), completed vaccine series AND DOES NOT have antibody response following 3rd dose (or booster) of COVID-19 vaccine

☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)

☐ Advanced or untreated HIV infection (people with HIV and CD4 cell counts <200/mm^3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV)

☐ Active treatment with high-dose corticosteroids (i.e., ≥20 mg prednisone or equivalent per day when administered for ≥2 weeks)

I, the referring provider, am the patient's PCP or other continuity provider and have arranged for the patient to follow up with me/my designee following Evusheld administration.

****— Indicates Provider Agreement**

**** Please provide the following information:**

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Evusheld for Pre-exposure Prophylaxis Against COVID-19 (continued)

☐ If patient meets the above criteria, give available EAU-approved monoclonal antibody pre-exposure prophylaxis as appropriate according to the EUA dosage and administration instructions per protocol.

Provider Signature_____ Date/Time_____

ICD-10 codes (Circle appropriate code):

Encounter codes:

Z23 Encounter for immunization
Z29.8 Encounter for other specified prophylactic measures
Z41.8 Encounter for other procedures for purposes other than remedying health state

Patient condition codes:

Z28.04 Immunization not carried out because of patient allergy to vaccine or component
Z28.09 Immunization not carried out because of other contraindication
Z92.21 Personal history of antineoplastic chemotherapy
Z92.22 Personal history of monoclonal drug therapy
Z92.241 Personal history of systemic steroid therapy
Z92.25 Personal history of immunosuppression therapy
Z92.3 Personal history of irradiation

The Infusion Center staff will communicate with the referring provider regarding clarification of the patient's criteria for treatment. The referring provider should provide as much detail as possible regarding the patients eligibility for therapy.

Name of Referring Site:_____ Point of Contact:_____
Address:_____
Phone Number:_____ Fax Number:_____
Email address:_____ Preferred mode of contact: ☐ Phone ☐ Fax ☐ Email

Patient's Primary/Continuity Care Provider (if different from above)
Office Name:_____
Address:_____ Phone Number:_____
Email address:_____ Fax Number:_____

REG.REFER