Ochsner Monoclonal Antibody Referral & Criteria Form

Patient's Name: _____ DOB: _____ MRN: _____

Patient Contact Number: _____

Date of COVID-19 Symptom Onset: _____ Date of Positive COVID-19 Test: _____

Symptom onset and positive viral test for SARS-CoV2 within last 10 days? ☐ Yes ☐ No

Patient is ≥ 12 years old and weighs ≥ 40 kg? ☐ Yes ☐ No

Criteria for Use of COVID-19 Antibody Treatment

COVID-19 Monoclonal Antibody Treatment is approved for Emergency Use Authorization only. Patients must meet all of the following requirements:

- Age ≥12 years of age, weighing at least 40 kg **AND**
- **NOT** receiving NEW supplemental oxygen / **NOT** hypoxic (SpO2 >94% on room air) **AND**
- Symptomatic with symptom onset within 7-days **AND**
- Positive COVID-19 test **AND**
- "COVID-19 Risk of Complications Score of ≥ 3"
    - *Note:* This score is subjected to change based on medication inventory. Should the supply become more limited, the score will be increased.

COVID-19 Risk of Complications Score ≥ 3 will be eligible to receive sotrovimab **OR** bebtelovimab

COVID-19 Risk of Complications Score

RISK FACTOR	POINT ASSIGNMENT
Is immunocompromised	_____ Has a qualifying condition – 1 point • Patient has HIV diagnosis • Patient is undergoing chemotherapy • Patient has an iatrogenic immunosuppression diagnosis • Patient is taking immunosuppressant drugs
Age	_____ 60-69 years old – 1 point _____ 70-79 years old – 2 points _____ 80 years or older – 3 points
Legal sex	_____ Male – 1 point
Nursing home residence	_____ Patient is in a nursing home – 1 point
Pregnancy status	_____ Is pregnant – 1 point
Has congestive heart failure	_____ Has a qualifying condition – 1 point
Has congenital heart disease	_____ Has a qualifying condition – 1 point
Has coronary artery disease (CAD)	_____ Has a qualifying condition – 1 point
Has end-stage renal disease	_____ Has a qualifying condition – 1 point
Has end-stage liver disease	_____ Has a qualifying condition – 1 point
Has chronic pulmonary disease	_____ Has a qualifying condition – 1 point
Has diabetes	_____ Has a qualifying condition – 1 point
Has hypertension	_____ Has a qualifying condition – 1 point
Is obese	_____ Has a qualifying condition – 1 point
Total Patient Risk Score	_____

RISK CATEGORY	POINT RANGE
High Risk	6-16 points
Moderate Risk	3-5 points
Low Risk	0-2 points

Referring Physician Signature: _____ Date: _____ Time: _____

Referring Physician (Print): _____

Phone: _____ Fax: _____

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Referral & Criteria Form
(Referral and Treatment)

Patient Section and Treatment Initiation

This section provides essential information on the emergency use authorization (EUA) product of Evusheld (tixagevimab/cilgavimab) for pre-exposure prophylaxis for prevention of COVID-19 in adults and adolescents. Evusheld is a long-acting monoclonal antibody dual injection that received an EUA from the Food & Drug Administration (FDA) for Covid-19.

EUA Fact Sheet links:

1. Patients and Caregivers:

   https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/6d1d5fea-2532-46e9-a1d4-1504f6dd41b2/6d1d5fea-2532-46e9-a1d4-1504f6dd41b2_pi_med_guide_rendition__c.pdf

2. Healthcare Providers:

   https://den8dhaj6zs0e.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/6d1d5fea-2532-46e9-a1d4-1504f6dd41b2/6d1d5fea-2532-46e9-a1d4-1504f6dd41b2_viewable_rendition__v.pdf

Referral can be made for any patient who are eligible by criteria listed below.

Patients will be eligible to receive Evusheld for COVID PrEP if the meet the following criteria:

- Patients ≥ 12 years old AND ≥ 40 kg **AND**
- Vaccinated **AND**
- Not currently infected with SARS-CoV-2 and not had a known recent exposure to an individual infected with SARS-CoV-2 (prior 10 days) **AND**
- Increased risk of severe disease **AND** not expected to mount an adequate immune response after 2 doses of mRNA vaccine or equivalent **OR**
- For whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s)

The matrix was created by a multidisciplinary pharmacist and physician workgroup representing hematology/oncology, solid organ transplant, bone marrow transplant, rheumatology, neurology, and infectious disease physicians. Unfortunately, supply is extremely limited at this time and available only through federal government allocation. Therefore, **evusheld administration is subject to current on hand inventory**.

Evusheld will be offered in Greater New Orleans, St. Tammany, Baton Rouge, Lafayette and Shreveport until such time as we can procure additional inventory. Our goal is to offer evusheld to all of our patients who are immunocompromised and unable to mount an adequate immune response to COVID-19 vaccination. Should supply become limited, the prioritization matrix will be used to determine patient eligibility.

Check box in Tier priority in which qualifies patient: Please note that completion of this referral does not guarantee the medication will be administered. Evusheld administration will be determined by current inventory.

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Referral & Criteria Form

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Prioritization Category	Qualifying Immunosuppression
Tier 1 ☐	• Received lymphocyte depleting agents within last 6 months • Current treatment with BTK inhibitors
Tier 2 ☐	• Allogeneic HCT or CAR-T therapy within prior 3 months • Severe primary immunodeficiencies • Lung Transplants ≤ 6 months • Solid organ transplant patients receiving belatacept
Tier 3 ☐	• Auto HCT within 3 months • Any Solid organ transplant w/in prior 6 months
Tier 4 ☐	• Active treatment for malignancy • AIDS
Tier 5 ☐	Any other immunosuppressing disease or treatment
Tier 6 ☐	Unable to receive any approved or authorized COVID-19 vaccine due to history of severe adverse reaction to a COVID-19 vaccine or COVID-19 vaccine component

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT PHONE NUMBER _____ REFERRING PROVIDER _____

PHYSICIAN SIGNATURE _____ DATE _____

Administration:

- Tixagevimab and cilgavimab must be administered by a qualified healthcare provider.
- Administer the two components of EVUSHELD (tixagevimab and cilgavimab) consecutively.
- Administer the IM injections at different injection sites, preferably one in each of the gluteal muscles, one after the other.
- **DO NOT** injection into skin that is tender, damaged, bruised, or scarred.
- Clinically monitor individuals after injections and **observe for at least 1 hour**
- Follow disposal code on MAR for disposal instructions of this medication.

SEND REFERRAL and PATIENT FACE SHEET TO:

- **Fax** — 504-842-8416
- **QUESTIONS:** Please call 1-855-312-4190 or 504-842-7436.