Cascade ID & Infusion

Specialty Order Form

Patient:_____	Ordering Provider:_____
DOB:_____ ☐M ☐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.

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 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:**_____