



Cascade ID & Infusion
Specialty Order Form

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

- Tixagevimab 300mg and Cilgavimab 300mg via IM Injection every 6 months.

PRN-Medication(s):

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

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

***Orders will need to be renewed yearly.

Physician's Signature: _____ **Date:** _____