



Baptist Health

MEDICAL CENTER
Little Rock

EVUSHELD Provider Referral Form

Patient Name: _____

DOB(Age): _____ (_____) Patient Contact Number: _____

Physician or Clinic Name: _____

Physician Fax Number: _____

Evusheld or Pre-Exposure Prophylaxis against COVID-19 is to be given to patients who are not currently infected with SARS-CoV-2 and do not have known recent exposure to someone with SARS-CoV-2. It is also to be given to patients with moderate to severe immunocompromised due to medical conditions or for someone for whom 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(s) and/or COVID-19 vaccine component(s).

Please Mark any of the Following That Applies:

- Active treatment for solid tumor and hematologic malignancies
- Receipt of solid-organ transplant and taking immunosuppressive therapy
- Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- 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/mm³, 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), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell depleting agents)
- Severe allergic reaction to COVID-19 vaccine or COVID-19 vaccine components.
- Additional Comments: _____

COVID-19 Vaccination Status:

- Fully Vaccinated (Date of last vaccine _____)
- Partially Vaccinated (Date of last vaccine _____)
- Not Vaccinated

Exclusions:

Any patient <18 years of age should be referred to Arkansas Children’s Hospital
Any patient <40kg

To discuss a possible referral during business hours, call **501-202-4630**
To complete referral please fax this form and a face sheet to **501-202-4635**