MERITUS MEDICAL CENTER

Informed Consent for Evusheld Injection

Patient Name:				Date:	
Date of Birth:		Age:		MRN:	

I understand that I have been referred by an authorized, licensed prescriber to receive Evusheld (Tixagevimab and Cilgavimab). The Food and Drug Administration (FDA) has issued an emergency use authorization (EUA) for this injection. Evusheld is for pre-exposure prevention of COVID-19 infection in adults and pediatric individuals (12 years of age and older weighing at least 40 kg) at high risk for severe disease and who are unable to receive a COVID-19 vaccine.

It has been explained to me that I am eligible to receive Evusheld under the FDA's EUAs.

1. I understand that the FDA has authorized emergency use of Evusheld for the purposes of preventing COVID-19 infection.
2. I understand that consent for this treatment is voluntary. I have the option to accept or refuse administration of Evusheld, including the option to refuse the injection.
3. I have been given a copy of the applicable FDA's Fact Sheet for Patients and Parents/Caregivers and have been given the opportunity to discuss it with my provider.
4. I have been informed of the potential risks and benefits of Evusheld and the extent to which such risks and benefits are unknown.
5. I have been informed of any available alternative treatments and the risks and benefits of those alternatives.
6. I understand that if I have received a COVID-19 vaccine that I should not receive Evusheld until 2 weeks after I received the vaccine.
7. I have been informed that Evusheld is not guaranteed to prevent me from getting COVID-19 and that I should still follow all other safety measures to prevent infection.

Before signing:

- **Carefully read this form and the FDA's Fact Sheet for Patients and Parents/Caregivers or have them read to you.**
- **Listen to your healthcare clinician explain the treatment to you.**
- **Please ask questions about anything that is not clear.**

By signing below, I certify that I have read and understand the information provided to me and consent to receive Evusheld. I hereby authorize Meritus Medical Center and its agents to administer Evusheld and to perform such additional procedures as are considered necessary to monitor and provide care for the duration of this treatment course.

Printed Patient Name: ______________________________

Patient or Authorized Representative Signature: ______________________________ Date: __________