IMPORTANT NOTICE – REVISED ONTARIO HEALTH RECOMMENDATION ON EVUSHELD

As of December 2022:

- Ontario Health no longer recommends routine use of Evusheld for pre-exposure prophylaxis for any patient group, including immunocompromised patients.

This document is now archived and will not be updated.

Health care providers can review the following documents for information about Evusheld:

- Ontario Health Recommendation on the Use of Evusheld
- Evusheld patient handout
- Evusheld product monograph
- Health Canada Health Professional Risk Communication on Evusheld

Information about Evusheld (Tixagevimab and Cilgavimab)
Reference for health care providers who may be prescribing or administering Evusheld

Last updated: October 3, 2022

The information in this document was developed based on best available evidence and expert consensus as of the date of publication. There are limitations to the evidence that is currently available. Information about Evusheld, including its effectiveness against different variants of COVID-19, is evolving rapidly. Prescribers must determine whether adopting suggested information is clinically appropriate for individual patients through a risk-benefit assessment.

Table of Contents

How this document was developed ..................................................................................................................... 2
Background ........................................................................................................................................................... 2
What is Evusheld .................................................................................................................................................. 3
Who is eligible for Evusheld in Ontario ................................................................................................................ 3
Evusheld dosage and administration ................................................................................................................... 6
Clinical evidence: PROVENT trial ......................................................................................................................... 8
Efficacy .................................................................................................................................................................. 8
How this document was developed

An Evusheld Clinical Working Group was convened in spring 2022 to develop this document. The Working Group included experts in the areas of infectious diseases, oncology, solid organ transplant, rheumatology, immunology, nephrology, and pediatrics. Working Group members consulted with colleagues in their specialty area for additional input. A draft document was prepared based on the available evidence, drug implementation advice from the Canadian Agency for Drugs and Technologies in Health (CADTH), and the Working Group’s clinical expertise. The content of the document was validated by all Working Group members. Working Group members are listed in Appendix A.

October 2022 update

This document was reviewed and updated by the Working Group to:

- Outline additional eligible populations (see Who is eligible for Evusheld in Ontario)
- Reflect new information regarding dosing and efficacy against Omicron BA.4 and BA.5 (see Evusheld dosage and administration)
- Outline new pathways for access to Evusheld (see How to access Evusheld)

Background

Although vaccines protect most people, some immunocompromised populations may have a reduced immune response to COVID-19 vaccination. There is an unmet need for additional protection against COVID-19 infection in patients who are immunocompromised and may have an inadequate response to vaccinations and in patients who have a contraindication to vaccination. Pre-exposure COVID-19 prophylaxis (prevention) may provide some protection for these patient populations.\(^1\)\(^2\)\(^3\)
What is Evusheld

Evusheld is a combination of two long-acting antibodies (tixagevimab and cilgavimab) that bind to distinct, non-overlapping epitopes of the SARS-CoV-2 spike-protein receptor-binding domain. This potentially blocks interaction with the host cellular receptor, inhibits entry, and neutralizes the virus.¹²

Evusheld is indicated for the pre-exposure prophylaxis of COVID-19 in adults and adolescents (≥ 12 years of age weighing at least 40 kg), who have NOT had a known recent exposure to an individual infected with COVID-19 and:

- Who are immunocompromised and are unlikely to mount an adequate immune response to vaccination, or
- For whom COVID-19 vaccination is not recommended.¹

Recent exposure means that the patient has had contact with a confirmed case and is still within the timeframe to develop COVID-19 from that exposure (e.g., 8 days).⁴

Evusheld is administered via two separate intramuscular injections concurrently and is expected to offer protection against symptomatic COVID-19 infection for 6 months or more.²

Place in therapy:

The goal of Evusheld treatment is to reduce symptomatic illness for individuals who are at a high risk of COVID-19 infection.

The primary strategy to protect against severe outcomes from COVID-19 is vaccination. Patients should receive all doses of a COVID-19 vaccine they are eligible for before Evusheld is considered. Evusheld is NOT a substitute for vaccination in individuals for whom COVID-19 vaccination is recommended. At this time, Evusheld is NOT indicated for the treatment of COVID-19, or for the prevention of disease after recent exposure to COVID-19.

Evusheld may provide an additional layer of protection for certain patients. It is strongly recommended that patients continue to limit potential exposure to SARS-CoV-2 through public health measures such as masking and limiting contacts.

Who is eligible for Evusheld in Ontario

Evusheld can be considered for the following people at the highest risk of having an inadequate response to vaccination, upon discussion of the risks and benefits:⁵

- Solid organ transplant recipients
- Stem cell transplant recipients
- CAR-T cell therapy recipients
- Other hematologic cancer patients undergoing treatment
- People receiving anti-B-cell therapy (e.g., rituximab) (new as of October 2022)
People with significant primary immunodeficiency (new as of October 2022)

Evusheld is not recommended for immunocompromised patients beyond these groups.

To be eligible for treatment, patients must:

- Be at least 12 years old
- Weigh at least 40 kg
- Not have a current COVID-19 infection
- Not have a recent COVID-19 exposure

Before receiving Evusheld, eligible individuals should be screened to ensure they are not currently symptomatic or known to be infected with COVID-19. Individuals should also be screened to ensure they have no recent high-risk exposure to a confirmed or probable case of COVID-19 during the close contact’s period of communicability. PCR, rapid antigen, and antibody testing are not required prior to receiving Evusheld.3

Who may benefit the most from Evusheld

Patient populations that may benefit the most from Evusheld are those who are least likely to mount an adequate immune response to COVID-19 vaccination.1,2,3 Eligible patients who may benefit the most from COVID-19 prophylaxis treatment are outlined in Tables 1-3. Patients in all three Tier groups are eligible to receive Evusheld in Ontario. A patient-centred discussion to clarify risks and benefits should be held prior to prescribing Evusheld.3

Institutions should put in place the logistics to support and facilitate access to Evusheld, where needed. Clinicians will use their discretion regarding which eligible patients should receive Evusheld, recognizing that additional risk factors for severe COVID-19 (such as age, comorbidities, and health equity considerations) might influence decision-making.

Pediatric considerations

- **Malignant hematology:** The eligible patient populations are generally like those of adult patients, except for those conditions that do not typically occur among children (e.g., multiple myeloma). For children within these populations, narrower time frames for eligibility are recommended compared to those recommended for adults (Table 1).
- **Solid organ transplant:** Eligibility for pediatric populations aligns with adult populations (Table 2).
- **Equity in access:** In institutions where Evusheld access will be shared among adult and pediatric patients, a process should be in place to ensure equitable access between pediatric and adult patients.
Table 1: Malignant hematology patients who may benefit the most from Evusheld®

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Recommended Eligibility</th>
<th>Children (≥ 12 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Adults</td>
<td></td>
</tr>
<tr>
<td>CAR T-cell therapy</td>
<td>• Ideally within 1 year of CAR T-cell therapy&lt;br&gt;• Could be given prior to CAR T-cell therapy</td>
<td>• Within 3-6 months before OR&lt;br&gt;• Within 3-6 months after CAR T-cell therapy</td>
</tr>
<tr>
<td>Allogeneic stem cell transplant</td>
<td>• Ideally within 1 year of allogeneic stem cell transplant, or if patient remains on prednisone or other therapy with significant immuno-suppression effects&lt;br&gt;• Could be given prior to allogeneic stem cell transplant conditioning</td>
<td>• Within 3-6 months before OR&lt;br&gt;• Within 3-6 months after transplant</td>
</tr>
<tr>
<td>Malignant hematology patients treated with CD-20 inhibitors</td>
<td>• Patients on active treatment, or within 6 months of treatment</td>
<td>• Patients on active treatment, or within 6 months of treatment</td>
</tr>
<tr>
<td>Tier 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant hematology patients treated with BTK inhibitors or venetoclax</td>
<td>• Patients on active treatment, or within 6 months of treatment</td>
<td>• Patients on active treatment, or within 6 months of treatment</td>
</tr>
<tr>
<td>Autologous stem cell transplant</td>
<td>• Ideally within 6 months of autologous stem cell transplant&lt;br&gt;• Could be given prior to autologous stem cell transplant</td>
<td>• Not routinely recommended</td>
</tr>
<tr>
<td>Tier 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other malignant hematology patients</td>
<td>• On active treatment, or within 3 months of active therapy</td>
<td>• Based on discretion of subspecialist and within 3 months if considered</td>
</tr>
</tbody>
</table>
Table 2: Solid organ transplant patients who may benefit the most from Evusheld

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Recommended Eligibility (all patients ≥ 12 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1</strong></td>
<td></td>
</tr>
<tr>
<td>Lung transplant</td>
<td>• All</td>
</tr>
<tr>
<td>Recent transplant</td>
<td>• &lt; 6 months</td>
</tr>
<tr>
<td>B-cell depletion (Rituximab)</td>
<td>• Within the last 6 months</td>
</tr>
<tr>
<td>Plasmapheresis/ATG for rejection (excluding patients with ongoing plasmapheresis)</td>
<td>• Within the last 3 months</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td></td>
</tr>
<tr>
<td>All organs</td>
<td>• Age ≥ 60 years</td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td></td>
</tr>
<tr>
<td>All organs</td>
<td>• Age &lt; 60 years</td>
</tr>
</tbody>
</table>

Table 3: Other patients who may benefit from Evusheld

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Recommended Eligibility (all patients ≥ 12 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People receiving anti-B-cell therapy (e.g., rituximab)</td>
<td>• All</td>
</tr>
<tr>
<td>People with significant primary immunodeficiency</td>
<td>• All</td>
</tr>
</tbody>
</table>

Patients who are immune competent with passive and/or active immunization are least likely to benefit from Evusheld.3

Evusheld dosage and administration

Recommended dose and administration:

The Health Canada product monograph states that 300 mg of Evusheld, administered as two separate sequential intramuscular (IM) injections (150 mg tixagevimab and 150 mg cilgavimab) at different injection sites, preferably one in each of the gluteal muscles is the standard dose.1 An increased dose of 600 mg (300 mg tixagevimab and 300 mg cilgavimab) is being used in other jurisdictions to address emerging evidence on reduced activity against currently circulating subvariants. Clinical judgement should be exercised when determining the dose of Evusheld.
• There is no information available around administration at other injection sites.\(^1,8\)

• Evusheld has only been studied as a single dose. There is limited safety and no efficacy data available on repeat dosing.\(^1,12\)

• The Health Canada product monograph recommends consideration of increasing the dose to 600 mg in regions where the Omicron subvariants BA.1 and BA.1.1 are circulating. These are the subvariants that were known to exist at the time of publication.

• There is emerging evidence to suggest that Evusheld has some activity against Omicron; however, there appears to be notably reduced activity against the currently prevalent Omicron subvariants BA.4 and BA.5, when compared to other subvariants (such as BA.2).\(^9,10,11,12,13,14,15\)

• Alberta Health Services and the FDA recommend an increased dose of 600 mg (300 mg tixagevimab and 300 mg cilgavimab), based on high levels of circulating BA.4 and BA.5.\(^11,12\)

• There are limited data in the prophylaxis setting for the 600 mg dose and there is limited safety data from a treatment study in patients with mild to moderate COVID-19 infection.\(^12,16\)

Updated guidance on dosing will be provided when more information becomes available.

Timing of administration:

• There are currently no data on concomitant administration of other treatments, such as chemotherapy. Based on drug interaction information and Evusheld’s mechanism of action, it is likely safe to give concomitantly with other treatments; however, due to the lack of data, timing of Evusheld in relation to administration with other treatments will have to be based on clinical judgement.\(^8\)

• In individuals who have received a COVID-19 vaccine, Evusheld should be administered at least 2 weeks after vaccination.\(^1\)

• If a patient is currently eligible for a COVID-19 vaccine dose, they should receive the vaccine before receiving Evusheld. There is very limited data available regarding COVID-19 vaccination after Evusheld administration.

• Post-COVID-19 infection, the patient should be recovered before Evusheld is administered. Consider waiting for two to three months before administering Evusheld.

Observation period:

• Clinically monitor individuals after injection based on standard protocols for IM injections (e.g., 15 minutes).

Storage and preparation:

• Evusheld is supplied as single-use vials that are stored in the refrigerator. No reconstitution is required. There is 4-hour stability at room temperature.\(^1\)

• Refer to the Evusheld product monograph for further information on storage, dosing, and administration.\(^1\)

• Care should be taken to ensure that antibodies are not mixed and that the same antibody is not given twice.
Clinical evidence: PROVENT trial

- PROVENT is an ongoing Phase III, randomised, double-blind, placebo-controlled, multi-centre trial assessing the efficacy and safety of an IM 300 mg dose (150 mg tixagevimab and 150 mg cilgavimab) of Evusheld compared to placebo for the prevention of symptomatic COVID-19 in patients who did not have a COVID-19 infection at baseline. The trial was conducted at 87 sites in the US, UK, Spain, France and Belgium.²
- 5197 patients were randomised in a 2:1 ratio to receive a single IM dose of either 300 mg of Evusheld (n = 3460) or saline placebo (n = 1737).¹⁻³
- The patient population consisted of unvaccinated people 18 years or older who have not had a previous COVID-19 infection. Patients were considered to be at an increased risk of inadequate response to active immunization or increased risk of infection due to location or circumstances, or both. There was a small subgroup of immunocompromised individuals (3.8% of the total study population).²
- Patients were excluded if they had a history of COVID-19 infection, a positive COVID-19 test at time of enrollment, or previous receipt of a vaccine or biological agent indicated for the prevention of COVID-19.²⁻³
- Primary endpoint of symptomatic COVID-19, defined as at least one of the following:
  - No minimum duration: fever, shortness of breath, difficulty breathing; or
  - Present for two or more days: chills, cough, fatigue, muscle aches, body aches, headache, new loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting, diarrhea.³

Efficacy

- Compared to placebo, Evusheld reduced the risk of developing symptomatic COVID-19 by 77% (95% confidence interval [CI] 46, 90; p<0.001) at the 3-month analysis. Symptomatic COVID-19 occurred in 8/3441 (0.2%) and 17/1731 (1.0%) patients in the Evusheld and placebo groups, respectively.
- At the 6-month extended analysis, there was an 83% relative risk reduction (95% CI 66, 91; no P-value calculated) with Evusheld. Symptomatic COVID-19 occurred in 11/3441 (0.3%) and 31/1731 (1.8%) patients in the Evusheld and placebo groups, respectively.²
- Number needed to treat: 68 patients need to be treated with Evusheld to prevent one case of symptomatic COVID-19 infection over 6 months.²
- There were no cases of severe/critical COVID-19, COVID-19-related deaths or hospitalizations in the Evusheld group by the six-month follow-up analysis; there were five cases of severe/critical disease, seven hospitalizations and two COVID-19-related deaths in the placebo group.
- No cases of COVID-19-related deaths were reported with Evusheld.²
- Protection against the virus lasted at least 6 months.²
- The PROVENT study was conducted when Delta was the dominant circulating variant. In laboratory testing, Evusheld appears to provide some protection against some Omicron subvariants (e.g. BA.2).¹
  There is emerging evidence that suggests Evusheld has reduced activity against the BA.4 and BA.5 subvariants.⁹⁻¹²
Limitations to the available evidence

- There is limited evidence regarding Evusheld prophylaxis in patients who have received any doses of a COVID-19 vaccine or in patients with previous history of COVID-19 infection.
- The PROVENT study did not provide efficacy information for the newest variants of concern that are prevalent in Ontario.
- The PROVENT study population did not include patients who are younger than 18 years old.
- The PROVENT study population did not include patients who are pregnant.
- Only a small percentage of the study population were immunocompromised.
- There were a low number of events overall, especially in clinical subgroups.
- Study participants eventually became aware of their randomised assignment in order to consider COVID-19 vaccination. These patients were not included in the longer-term, double-blinded follow-up.
- The role and potential impact of COVID-19 treatments (such as Paxlovid) is unclear.
- The exact duration of response is unknown (at least 6 months). There is limited safety and no efficacy data on repeat dosing.\(^1\),\(^12\)

Side effects/safety

- Evusheld is generally well tolerated. The most common side effects are:
  - Injection site reactions (pain, redness, itching and swelling at site of injection; 1.3%), and
  - Hypersensitivity reaction (rash or hives; 1%).
- Injection-related reactions (includes headache, chills and redness, discomfort or soreness near where the injection was given) were reported in less than 1% of patients.\(^1\)
- No anaphylaxis or serious hypersensitivity reactions have been reported with Evusheld. Serious hypersensitivity reactions, including anaphylaxis, have been observed rarely with other IgG1 monoclonal antibodies. If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate treatment.\(^1\)
- In PROVENT, there were more cardiovascular events in the Evusheld arm versus placebo (0.7% versus 0.3%) notably myocardial infarction and cardiac failure.\(^1\)\(^3\) Serious thromboembolic events were slightly higher in the Evusheld arm (0.5% versus 0.2%).\(^1\)\(^3\) Most patients had cardiac risk factors and/or a prior history of cardiovascular disease. A causal relationship has not been established.\(^1\),\(^2\)
- There were no deaths in either arm of PROVENT assessed as being related to the study drug or placebo.\(^2\)

Drug interactions

- No interaction studies have been conducted.\(^1\) Based on mechanism of action and metabolism, it is unlikely that there are clinically significant drug-drug interactions.
- Evusheld is not renally excreted or metabolised by cytochrome P450 enzymes.\(^1\)
• Based on PK modelling, COVID-19 vaccination following Evusheld administration had no clinically relevant impact on the clearance of Evusheld.¹

Contraindications and precautions

• Evusheld is contraindicated in individuals who have had a severe allergic reaction to Evusheld or any ingredient in Evusheld, including tixagevimab, cilgavimab, L-histidine, L-histidine hydrochloride, or polysorbate 80.¹

• Due to the increased incidence of cardiovascular and thromboembolic events in patients treated with Evusheld, caution should be used and a discussion of risks and benefits should be held with patients at high risk for cardiovascular or thromboembolic events.
  ○ Health Canada recommends prescribers consider the risks and benefits before initiating Evusheld in individuals at high risk for cardiovascular or thromboembolic events, and advise individuals to seek immediate medical attention if they experience any signs or symptoms suggestive of a cardiovascular or thromboembolic event.¹
  ○ CADTH has advised that Evusheld not be used in patients with a previous history of unstable cardiac conditions (e.g., myocardial infarction, unstable coronary artery disease).³

• As with any other intramuscular injection, Evusheld should be used with caution in individuals who have thrombocytopenia or bleeding disorders, or in those who are taking an anticoagulant.¹

• No information is available for use of Evusheld in pregnancy and breastfeeding. The potential benefits need to be weighed against the potential risks for the pregnant person, fetus, and breastfed child.¹

How to access Evusheld

There are various ways that patients can access Evusheld.

1. Access to Evusheld is offered through select hospital-based clinics, including cancer and transplant programs and some clinical assessment centres. Some clinics may accept referrals from providers in the community (check with the Ontario Health regional contact below).

2. Evusheld can be dispensed through pharmacies (new pathway effective October 3, 2022).
  • Physicians and nurse practitioners can prescribe the drug for pickup at a local pharmacy, with administration (i.e., injection) completed by the prescribing clinician or appropriate health care provider. Note that prescriptions for Evusheld may not be available for pick up same-day as pharmacies are likely to place orders for Evusheld upon receipt of a prescription (1–2 day turnaround).
  • Evusheld requires refrigeration storage (2°C – 8°C) and appropriate cold chain must be maintained.
• Pharmacies can dispense 300 mg or 600 mg doses (must be specified on the prescription).
• All prescribers who administer Evusheld will need to obtain patient consent and file a report with their local Public Health Unit as soon as possible to allow for entry into the COVAxOn reporting system. A consent and reporting template is available here.

As additional pathways to access Evusheld become available, information will be shared with health care providers.

Questions about access to Evusheld may be directed to the Ontario Health regional contacts listed in Appendix B.

Communication with eligible patients

Proactive communication with eligible patients about Evusheld can support them in receiving Evusheld before they get sick. This communication can also be an opportunity to recommend COVID-19 vaccine doses that patients may be eligible for. Providers are strongly encouraged to engage in the following ways with those who may be eligible:

• During appointments
• Via email or telephone
• By updating the organization’s website or online booking portal
• By working with community ambassadors and other partners to support outreach to equity-deserving populations
• By sharing relevant patient medication information about Evusheld

Equity considerations: Certain groups (particularly Indigenous people, Black people, and members of other equity-deserving communities) may be at increased risk of disease progression because of disparate rates of comorbidity, increased barriers to vaccination, and social determinants of health. Sites coordinating access to Evusheld should consider proactively reaching out to groups representing or supporting these populations in order to enhance awareness and facilitate access.

Key resources for health care providers, patients, and caregivers

• Evusheld product description (Health Canada): includes links to resources to obtain more information
• Evusheld consumer information (Health Canada): includes relevant questions and answers for patients and caregivers
• Evusheld patient handout: information about the safe and effective use of Evusheld for patients and caregivers
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christopher Simpson (co-Chair)</td>
<td>Executive Vice President, Medical, Ontario Health; Professor, Department of Medicine, Queen’s University; Cardiologist, Kingston Health Sciences Centre</td>
</tr>
<tr>
<td>Daniel Warshafsky (co-Chair)</td>
<td>Associate Chief Medical Officer of Health</td>
</tr>
<tr>
<td>Upton Allen</td>
<td>Professor, Department of Paediatrics, University of Toronto; Head, Division of Infectious Diseases, SickKids</td>
</tr>
<tr>
<td>Vanessa Allen</td>
<td>Medical Director, Provincial COVID-19 Diagnostic Network, Ontario Health; Microbiologist and Infectious Diseases Specialist, Sinai Health / University Health Network Department of Microbiology &amp; Division of Infectious Diseases</td>
</tr>
<tr>
<td>Mira Backo-Shannon</td>
<td>Vice President, Clinical Programs, Ontario Health Central</td>
</tr>
<tr>
<td>Andrea Crespo</td>
<td>Senior Pharmacist, Systemic Treatment, Cancer Programs, Ontario Health</td>
</tr>
<tr>
<td>Gerald Evans</td>
<td>Professor, Departments of Medicine, Biomedical &amp; Molecular Sciences and Pathology &amp; Molecular Medicine, Queen’s University; Medical Director, Infection Prevention &amp; Control, Kingston Health Sciences Centre</td>
</tr>
<tr>
<td>Leta Forbes</td>
<td>Provincial Head, Systemic Treatment Program, Ontario Health</td>
</tr>
<tr>
<td>Swapnil Hiremath</td>
<td>Associate Scientist, Clinical Epidemiology Program, Ottawa Hospital Research Institute; Associate Professor, Faculty of Medicine, University of Ottawa; Staff Nephrologist, Division of Nephrology, The Ottawa Hospital</td>
</tr>
<tr>
<td>Charles Hui</td>
<td>Associate Professor, Department of Paediatrics, University of Ottawa; Chief, Division of Infectious Diseases, Immunology, and Allergy, CHEO</td>
</tr>
<tr>
<td>Tom Kouroukis</td>
<td>Provincial Head, Complex Malignant Hematology, Ontario Health; Associate Professor, Department of Oncology, McMaster University; Hematologist/Oncologist, Juravinski Cancer Centre</td>
</tr>
<tr>
<td>Nader Khalidi</td>
<td>Division Director, Rheumatology, Department of Medicine, McMaster University</td>
</tr>
<tr>
<td>Deepali Kumar</td>
<td>Professor of Medicine, University of Toronto; Director, Transplant Infectious Diseases, University Health Network</td>
</tr>
<tr>
<td>Jane Purvis</td>
<td>Rheumatologist; Government Affairs Committee Lead, Ontario Rheumatology Association</td>
</tr>
<tr>
<td>Chaim Roifman</td>
<td>Professor of Paediatrics &amp; Immunology, University of Toronto;</td>
</tr>
<tr>
<td>Name</td>
<td>Position and Affiliation</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Darin Treleaven</td>
<td>Director, Canadian Center for Primary Immunodeficiency and Director, Fellowship Training Program, Division of Immunology/Allergy, Department of Pediatrics, SickKids</td>
</tr>
<tr>
<td></td>
<td>Clinical Lead, Transplantation, Ontario Renal Network &amp; Trillium Gift of Life Network, Ontario Health; Associate Professor, Division of Nephrology, McMaster University</td>
</tr>
<tr>
<td>Sharon Walmsley</td>
<td>Professor, Department of Medicine, University of Toronto; Director of Clinical Research, Immunodeficiency Clinic, University Health Network; Senior Scientist, Toronto General Hospital Research Institute</td>
</tr>
</tbody>
</table>

Note: Each member of the Working Group was asked to declare any actual, potential, or perceived conflicts of interest. A summary of disclosures is available [here](#).
### Appendix B. Ontario Health regional contacts

<table>
<thead>
<tr>
<th>Region</th>
<th>Contact Name(s)</th>
</tr>
</thead>
</table>
| Central           | Mira Backo-Shannon ([Mira.Backo-Shannon@ontariohealth.ca](mailto:Mira.Backo-Shannon@ontariohealth.ca))  
                    David Pearson ([David.Pearson@ontariohealth.ca](mailto:David.Pearson@ontariohealth.ca)) |
| East              | Farrah Hirji ([Farrah.Hirji@ontariohealth.ca](mailto:Farrah.Hirji@ontariohealth.ca))  
                    Lesley Ng ([Lesley.Ng@ontariohealth.ca](mailto:Lesley.Ng@ontariohealth.ca)) |
| Toronto           | [TOTherapeutics@ontariohealth.ca](mailto:TOTherapeutics@ontariohealth.ca) |
| West              | Karen M. Bell ([Karen.M.Bell@ontariohealth.ca](mailto:Karen.M.Bell@ontariohealth.ca))  
                    Heather Byrnell ([Heather.Byrnell@ontariohealth.ca](mailto:Heather.Byrnell@ontariohealth.ca))  
                    Tammy Meads ([Tammy.Meads@ontariohealth.ca](mailto:Tammy.Meads@ontariohealth.ca)) |
| North East and    | Jennifer MacKinnon ([Jennifer.MacKinnon@ontariohealth.ca](mailto:Jennifer.MacKinnon@ontariohealth.ca))  
                    North West | Robert Barnett ([Robert.Barnett@ontariohealth.ca](mailto:Robert.Barnett@ontariohealth.ca)) |
References


(3) CADTH. CADTH Drug Implementation Advice: Tixagevimab and Cilgavimab (Evusheld) [Internet]. 2022 Apr. Available from: https://www.cadth.ca/sites/default/files/hta-he/HD0008-Evusheld.pdf


(8) Email communication with AstraZeneca medical team. 2022 Apr 21.


