COVID-19 Treatment Center Form

Prescribers: Print Form, then Complete and Fax to BID-Plymouth 508 830-2789

NIH COVID Treatment Guidelines: https://www.covid19treatmentguidelines.nih.gov/


<table>
<thead>
<tr>
<th>NIH Tier</th>
<th>Patient characteristics*</th>
<th>Within 5 days of symptom onset</th>
<th>Between 5 – 7 days of symptom onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Moderate-to-severe immunosuppression; Not fully vaccinated and age ≥ 75 years; Not fully vaccinated and age ≥ 65 years plus additional risk factor</td>
<td>Nirmatrelvir/r (PAXLOVID) preferred.</td>
<td>Remdesivir preferred.</td>
</tr>
<tr>
<td>2</td>
<td>Not fully vaccinated and age ≥ 65; Not fully vaccinated and age &lt; 65 plus additional risk factor</td>
<td>If Nirmatrelvir/r not appropriate or available <strong>REMDESIVIR</strong> preferred.</td>
<td>If remdesivir not appropriate or available, <strong>BEBTELOVIMAB</strong> (mAb) preferred.</td>
</tr>
<tr>
<td>3</td>
<td>Vaccinated** and age ≥ 75; Vaccinated and age ≥ 65 years plus additional risk factor</td>
<td>REMDESIVIR preferred.</td>
<td><strong>BEBTELOVIMAB</strong> (mAb) preferred.</td>
</tr>
<tr>
<td>4</td>
<td>Vaccinated and age ≥ 65 years; Vaccinated and age &lt; 65 plus additional risk factor</td>
<td>Nirmatrelvir/r or remdesivir not appropriate or available, <strong>BEBTELOVIMAB</strong> (mAb) preferred.</td>
<td><strong>BEBTELOVIMAB</strong> (mAb) preferred.</td>
</tr>
<tr>
<td>N/A</td>
<td>Any adult (or pediatric patient over age 12 and &gt;40 kg) at increased risk of severe COVID-19</td>
<td>Within 5 days of symptom onset</td>
<td>Between 5 – 7 days of symptom onset</td>
</tr>
</tbody>
</table>

**Clinical risk factors include cancer, cardiovascular disease, chronic kidney disease, chronic lung disease, diabetes, immunocompromising conditions or receipt of immunosuppressive medications, obesity (body mass index ≥30), pregnancy, and sickle cell disease. For additional information on medical conditions and other factors that are associated with increased risk for progression to severe COVID-19, see the CDC webpage People With Certain Medical Conditions. The likelihood of developing severe COVID-19 increases when a person has multiple high-risk conditions or comorbidities. Medical conditions or other factors (e.g., social determinants of health) not listed may also be associated with high risk for progression to severe COVID-19. Therapeutics for COVID-19 may be considered for patients with multiple high-risk conditions or comorbidities and factors that are not listed in the EUAs. The decision to use monoclonal antibodies or antivirals for a patient should be based on an individualized assessment of risks and benefits. Use of monoclonal antibodies or antivirals that departs from tiering recommendations is permissible if based on clinical judgement.

**Vaccinated individuals who have not received a COVID-19 vaccine booster dose are at higher risk for severe disease.
REMDESIVIR PRESCRIPTION

**Step 1. SYMPTOMATIC COVID-19 Infection (fill out completely)**

Date of symptom onset (MM/DD/YY): ________ Date of Positive COVID-19 PCR/Antigen Test (MM/DD/YY): ________

Fully Vaccinated? (>2 weeks since receiving 2nd dose of Pfizer/Moderna or 1st of J&J) Circle One: YES NO

**Step 2. Treatment-qualifying condition(s)**

**Step 3. Complete PRESCRIPTION and send via secure email or fax**

REMDESIVIR Prescription

Patient Name (printed): ____________________________________ Sex: M/F/other DOB: __________

Allergies ____________________________________________ Patient weight (kg) ________

Patient Home Address

Patient Mobile Phone: _______________________________ Home Phone ________________

- **REMDESIVIR INFUSION GFR >30:** (wt>40kg) administer 200mg IV Day 1, 100mg IV day 2, 100mg IV day 3. Each infusion to run over 30-120 minutes. No refills. Must be give within 7 days of symptom onset. Reference: REMDESIVIR INFO.

- **REMDESIVIR INFUSION GFR >30:** (wt<40kg) administer ___mg IV (5mg/kg) Day 1, ___mg IV (2.5mg/kg) day 2, __mg IV (2.5mg/kg) day 3. Each infusion to run over 30-120 minutes. No refills. Must be give within 7 days of symptom onset. Reference: REMDESIVIR INFO.

**IMPORTANT:** Initial infusion must be scheduled Monday-Thurs to allow patient to receive 3 consecutive days of treatment. Please submit new remdesivir prescriptions before 11am on Wednesdays **

Should your patient be unable to be scheduled for remdesivir due to timing of referral, please indicate if you would like the patient to be considered for mAb (bebtelovimab) infusion:

Circle one: YES NO

Provider attestation:

I have reviewed the medical guidance of options for outpatient treatment of mild-moderate COVID 19 as per Massachusetts DPH guidance dated 07/19/22. I have reviewed the indications for, contraindications for, complications of, potential medication interactions, and side effects of the infusions(s) prescribed and have counseled the patient fully on risks and benefits accordingly. Where applicable, I have counseled on contraception and pregnancy concerns.

Prescriber name (print legibly) ____________________________ Prescriber phone _____________

Prescriber address (print) ______________________________

Prescriber email (print legibly) __________________________

Prescriber DEA ___________________________ Date ________________

Signature: ____________________________________________

**NO SUBSTITUTION**

Interchange mandated unless the practitioner indicates “no substitution” in accordance with the law

RN/NP/PA name (printed): ________________________________

RN/NP/PA signature: ________________________________ Date: ________________

Prescriber’s name: ________________________________

Send Referral to: BID-Plymouth (fax) 508 830-2789

For Inquires contact CWS Call Center @ 508 830-2778

BIDPlymouth October 2022