Beth Israel Lahey Health
Beth Israel Deaconess Hospital
Plymouth

COVID-19 IV Infusion Center Form

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

NIH COVID Treatment Guidelines: https://www.covid19treatmentguidelines.nih.gov/
Massachusetts DPH Clinical Guidance on Therapeutics for COVID-19 Massachusetts DPH
https://www.mass.gov/info-details/information-for-providers-about-therapeutic-treatments-for-covid-19#guidance

Table: Treatment recommendations for mild to moderate COVID-19.

Recommendation Based on symptom onset timeline

NIH Tier	Patient characteristics*		Within 5 days of symptom onset	Between 5 – 7 days of symptom onset
1	Moderate-to-severe immunosuppression; Not fully vaccinated and age ≥ 75 years; Not fully vaccinated and age ≥ 65 years plus additional risk factor	*Patients from all tiers*	Nirmatrelvir/r **(PAXLOVID)** preferred. If Nirmatrelvir/r not appropriate or available **REMDESIVIR** preferred. If nirmatrelvir/r or remdesivir not appropriate or available, **BEBTELOVIMAB (mAb)** preferred.	Remdesivir preferred. If remdesivir not appropriate or available, bebtelovimab may be used.
2	Not fully vaccinated and age ≥ 65; Not fully vaccinated and age < 65 plus additional risk factor			
3	Vaccinated** and age ≥ 75; Vaccinated and age ≥ 65 years plus additional risk factor			
4	Vaccinated and age ≥ 65 years; Vaccinated and age < 65 plus additional risk factor			
N/A	Any adult (or pediatric patient over age 12 and >40 kg) at increased risk of severe COVID-19			

*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.

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ORAL ANTIVIRAL 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

Oral Antiviral Prescription

Patient Name (printed): _____ **Sex:** M/F/other **Patient DOB:**

Allergies_____ **Attesting patient weighs >40Kg 88.1 Lbs: YES**

Patient Home Address_____

Patient Mobile Phone: _____ **Home Phone** _____

O PAXLOVID (***NORMAL GFR):*** Take 2 nirmatrelvir 150 mg tabs + 1 ritonavir 100 mg tab by mouth twice daily x 5 days. Dispense 30 tablets. No refills. Must be initiated within 5 days of symptom onset. References: ***PAXLOVID INFO.***
Prescribing provider is responsible for patient counseling and checking for drug interactions: Liverpool Interaction Checker.

O PAXLOVID (*GFR 30-60*): Take 1 nirmatrelvir 150 mg tab + 1 ritonavir 100 mg tab by mouth twice daily x 5 days. Dispense 20 tablets. No refills. Must be initiated within 5 days of symptom onset. References: ***PAXLOVID INFO.*** **Prescribing provider is responsible for patient counseling and checking for drug interactions: Liverpool Interaction Checker.**

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 treatment or medication(s) prescribed on this form 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:** _____

Prescribers name:_____

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

For Inquires contact CWS Call Center @ 508 830-2778

BIDPlymouth October 2022