Beth Israel Lahey Health
Beth Israel Deaconess Hospital
Plymouth

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/

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

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, can consider molnupiravir.	Remdesivir preferred.
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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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/Novavax or 1st of J&J or bivalent mRNA vaccine) 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**: (**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**: (**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 04/26/22**. 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 @ 508 830-2788

BIDPlymouth September 2022

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