

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>

NIH Tier	Patient characteristics*	Recommendation Based on symptom onset timeline	
		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	<p><i>Patients from all tiers</i></p>	<p>Nirmatrelvir/r (PAXLOVID) preferred.</p> <p>If Nirmatrelvir/r not appropriate or available REMDESIVIR preferred.</p> <p>If nirmatrelvir/r or remdesivir not appropriate or available, BEBTELOVIMAB (mAb) preferred.</p>
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.

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