Long Term Care

Nirmatrelvir + Ritonavir (PAXLOVID™) for Oral Treatment of COVID-19 in Adults

These orders are to be used as a guideline and do not replace sound clinical judgement and professional practice standards. Patient allergy and contraindications must be considered when completing these orders.

■ Automatically activated (If not in agreement with an order cross out and initial). ☐ Requires a check (√) for activation

Allergies: ☐ **Unknown** ☐ **No** ☐ **Yes (describe)**_____

Serum creatinine:_____**umol/L** **eGFR:**_____**mL/min** **Date:** _____

CRITERIA FOR PCH COVERAGE

Contraindications:

- ■ Severe hepatic impairment (Child-Pugh Class C)
- ■ Absolute drug contraindications: phenytoin, carbamazepine, phenobarbital, amiodarone, tacrolimus, or St. John's Wort

Criteria:

- ■ Positive results of SARS-CoV-2 viral testing
- ■ Moderate symptoms of COVID-19
- ■ Onset within the last 5 days[1]
- ■ Able to swallow tablets whole
- ■ ***Select <u>at least one</u> criterion indicating severe or moderate immunosuppression:***

Severe immunosuppression

- ☐ Recipient of solid organ transplant[2]
- ☐ Treatment for a malignant hematologic condition[3]
- ☐ Bone marrow transplant, stem cell transplant, or transplant-related immunosuppressant use[4]
- ☐ Receipt of an anti-CD20 drug or B cell–depleting drug in the past 2 years[5]
- ☐ Severe primary immunodeficiencies[6]

Moderate immunosuppression

- ☐ Treatment for cancer, including solid tumours[7,8]
- ☐ Treatment with significantly immunosuppressing drugs[9-12]
- ☐ Advanced HIV infection (treated or untreated)[13]
- ☐ Moderate primary immunodeficiencies[14]
- ☐ Renal conditions (e.g., hemodialysis, peritoneal dialysis, glomerulonephritis and dispensing of a steroid, eGFR less than 15 mL/min/1.73 m^2)

MEDICATION ORDERS

eGFR greater than or equal to 60 mL/min:

☐ nirmatrelvir 300 mg oral q12h x 5 days
AND
ritonavir 100 mg oral q12h x 5 days

eGFR 30-59 mL/min:

☐ nirmatrelvir 150 mg oral q12h x 5 days
AND
ritonavir 100 mg oral q12h x 5 days

eGFR less than 30 mL/min (no dialysis):

☐ nirmatrelvir 300 mg oral once daily on day 1 AND
ritonavir 100 mg oral once daily on day 1
THEN,
nirmatrelvir 150 mg oral once daily on days 2-5 AND
ritonavir 100 mg oral once daily on days 2-5

Dialysis Patients:

**On dialysis days, give <u>AFTER</u> dialysis*

☐ nirmatrelvir 300 mg oral once daily on day 1* AND
ritonavir 100 mg oral once daily on day 1*
THEN,
nirmatrelvir 150 mg oral once daily on days 2-5* AND
ritonavir 100 mg oral once daily on days 2-5*

PRESCRIBER'S SIGNATURE:_____PRINTED NAME:_____Date_____Time _____

Order Transcribed	FAX/SCAN TO PHARMACY
Date:_____Time:_____Init _____	Date:_____Time:_____Init _____

Instructions for Use

1. Complete the addressograph section.
2. Document the resident's serum creatinine and/or eGFR (using the CKD-EPI equation) in the space provided and indicate the date the measurement was done. The eGFR CKD-EPI equation can be found on www.mdcalc.com.
3. Orders with solid boxes (■) are standard orders. If not in agreement with an order, cross out and initial. Orders with open boxes (□) requires a checkmark (✓) for activation.
4. Under the Criteria for PCH Coverage section:
    a. Review the contraindications for nirmatrelvir + ritonavir (Paxlovid™)
    b. Review the minimum criteria for nirmatrelvir + ritonavir (Paxlovid™)
    c. If the resident meets the criteria and does not have contraindications, select at least one criterion indicating severe or moderate immunosuppression (see footnotes below)
5. Under the Medication Orders section, check the box for the appropriate dose of nirmatrelvir + ritonavir (Paxlovid™) based on eGFR.
6. Complete "Prescriber Signature", "Printed Name" and "Date" and "Time". If the order is given by phone, the healthcare professional should document it as a telephone order and the prescriber should co-sign at their next visit to the facility.
7. Fax to Pharmacy. Enter "Date" and "Time" sent and "Initials". Generic substitution authorized unless otherwise specified.
8. File in the Orders Section of the resident health record.
9. DO NOT change the order form after its initial completion. Any order changes should be documented as a new prescriber order in the resident health record.

Footnotes:

1. The symptom window for nirmatrelvir/ritonavir can be extended to 7 days if the resident would otherwise be referred for remdesivir solely based on its longer treatment window.
2. Solid organ transplant recipients of kidney, liver, lung, heart, pancreas or islet cell, bowel or combination transplant.
3. Are receiving or have received in the last year active treatment (e.g., chemotherapy, targeted therapies including chimeric antigen receptor T cell therapy [CAR-T], immunotherapy) for malignant hematologic conditions (e.g., leukemia, lymphoma, or myeloma).
4. Have had bone marrow or stem cell transplant in the last 2 years or who are currently on immunosuppressants for graft vs. host disease (GVHD).
5. Have received treatment with any anti-CD20 agents (e.g., rituximab, ocrelizumab, ofatumumab, obinutuzumab, ibritumomab, tositumomab) or B-cell depleting agents (e.g., epratuzumab, MEDI-551, belimumab, BR3-Fc, AMG-623, Atacicept, anti-BR3, alemtuzamab) in the last 2 years.
6. Have combined immune deficiencies affecting T-cells, immune dysregulation (particularly familial hemophagocytic lymphohistiocytosis) or those with type 1 interferon defects (caused by a genetic primary immunodeficiency disorder or secondary to anti-interferon autoantibodies)
7. Are receiving or have received in the last 6 months systemic therapy (including chemotherapy, molecular therapy, immunotherapy, targeted therapies including CAR-T, monoclonal antibodies other than the hematological malignancies above, EXCEPT those receiving adjunctive hormonal therapy ONLY
8. Are receiving or have received in the last 3 months radiation therapy for cancer
9. Biologics taken in the last 3 months: abatacept, adalimumab, anakinra, benralizumab, brodalumab, canakinumab, certolizumab, dupilumab, etanercept, golimumab, guselkumab, infliximab, interferon products (alpha, beta, and pegylated forms), ixekizumab, mepolizumab, natalizumab, omalizumab, resilizumab, risankizumab, sarilumab, secukinumab, tildrakizumab, tocilizumab, ustekinumab, or vedolizumab.
10. Oral immune-suppressing drugs taken in the last month: azathioprine, baricitinib, cyclophosphamide, cyclosporine, leflunomide, dimethyl fumerate, everolimus, fingolimod, mycophenolate, siponimod, sirolimus, tacrolimus, tofacitinib, upadacitinib, methotrexate, or teriflunomide.
11. Oral steroids on an ongoing basis in the last month: equivalent to 20 mg/day of prednisone - dexamethasone, hydrocortisone, methylprednisolone, or prednisone.
12. Immune-suppressing infusions/injections taken in the last 3 months: cladribine, cyclophosphamide, glatiramer, methotrexate.
13. Advanced untreated HIV infection or those with acquired immunodeficiency syndrome (AIDS) defined as AIDS defining illness or CD4 count less than or equal to 200/mm^3 or CD4 fraction less than or equal to 15%. Consider consultation with the HIV Clinic regarding drug interactions.
14. Have a moderate to severe primary immunodeficiency which has been diagnosed by an immunologist and requires ongoing immunoglobulin replacement therapy (IVIg or SCIG) or the primary immunodeficiency has a confirmed genetic cause (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome).

Adapted from Canada's Drug Agency Reimbursement Recommendation: Nirmatrelvir-Ritonavir (Paxlovid), April 2024