Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Prescriber's Order Sheet

Long Term Care Remdesivir for Management of COVID-19 in Adults

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

■ *Standard orders. If not in agreement with an order, cross out and initial.* ☐ *Requires a check (✓) for activation.*

Weight: _____ kg Date: D D M M M Y Y Y Y

eGFR: _____ mL/min Date: D D M M M Y Y Y Y

℞ MEDICATION ORDERS
TO BE INITIATED OR DISCONTINUED

Conditional order pending review by Community IV Program (CIVP)

☐ For PCH residents with **severe COVID-19 on supplemental oxygen (above their baseline):** Remdesivir 200 mg IV x 1 dose (day 1), followed by 100 mg IV daily x 4 days (day 2, 3, 4 & 5)

☐ For PCH residents with moderate symptoms of COVID-19 who cannot take Paxlovid™ AND have **at least one criterion indicating severe or moderate immunosuppression**[1] (check off below): Remdesivir 200 mg IV x 1 dose (day 1), followed by 100 mg IV daily x 2 days (day 2 and 3)

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, or eGFR less than 15 mL/min/1.73 m^2)

GENERAL ORDERS

- ■ Contraindicated in residents with severe hepatic dysfunction or alanine aminotransferase (ALT) greater than 5 times the upper limit of normal
- ■ Drug interactions: chloroquine and hydroxychloroquine can diminish the efficacy of remdesivir if prescribed concurrently
- ■ Assess if remdesivir is consistent with the resident's goals of care and consent obtained
- ■ Complete the **COVID-19 IV Antiviral Outpatient & Personal Care Home Treatment Referral Form.**
- ■ Fax referral form and prescriber's order sheet to 204-233-0086 for centralized referral management by Community IV Program (CIVP)
- ■ Recommended monitoring parameters:
  - Blood pressure (hypotension)
  - Heart rate (bradycardia)

Prescriber Signature:	Prescriber Printed Name:	Date D D M M M Y Y Y Y	Time 24 HOUR

☐ Faxed to Community IV Program (CIVP)	Initials	Date D D M M M Y Y Y Y	Time 24 HOUR	*Generic substitution authorized unless otherwise specified.*

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Instructions for Use

- These orders are intended for COVID-19 positive residents remaining within the LTC/PCH setting who are eligible for COVID-19 IV antiviral treatment.
- These orders are to be used as a guideline and do not replace sound clinical judgment and professional practice standards.
- Resident allergy and contraindications must be considered when completing these orders.

Procedure:

1. Complete the addressograph section.
2. Enter the resident's weight (in kilograms) and eGFR (using the CKD-EPI equation) in the space provided and indicate the date the measurement was done.
3. Orders with solid boxes (■) are standard orders. If not in agreement with an order, cross out and initial.
4. Orders with open boxes (□) require a check (✓) for activation.
5. The order for remdesivir is conditional pending review by the Community IV Program to ensure the resident's eligibility based on the provincial criteria.
6. Review the contraindications and monitoring parameters under "General Orders".
7. Review the 2 scenarios for PCH resident eligibility for IV antiviral COVID-19 treatment. Check off (✓) the appropriate remdesivir course.
8. Complete the current version of the COVID-19 IV Antiviral Outpatient & Personal Care Home Treatment Referral Form.
9. Complete "Prescriber Signature", "Prescriber Printed Name" and "Date" and "Time". CIVP requires a prescriber signature for the remdesivir order. A telephone order taken by a nurse cannot be accepted.
10. Fax referral form and prescriber's order sheet to 204-233-0086 for centralized referral management by Community IV Program (CIVP). Check the box "Orders Faxed to Community IV Program (CIVP)", initial, and enter "Date" and "Time" sent. Generic substitution authorized unless otherwise specified.
11. Place order form in the Orders Section of the resident health record.
12. **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/mm3 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: Remdesivir, September 2024