# PAXLOVID (RITONAVIR/NIRMATRELVIR) REFERRAL FORM & PRESCRIPTION

- This form can be used to refer and prescribe PAXLOVID (Ritonavir/Nirmatrelvir) for patients in the City of Toronto
- **Please fill in sections A-E of this form** and email it to COVIDCare@uhn.ca or fax 416-340-4135.
- Please contact the UHN Connected COVID Clinic if you have questions before completing the form at COVIDCare@uhn.ca or **437-488-1650.** If an individual needs to be assessed in person for COVID-19 therapeutics, please contact the Women's College COVID-19 Clinical Assessment Centre to make a referral at: **416-804-4083**.

## SECTION A: Patient Demographics

| | |
|---|---|
| **Full Name:** | **MRN** (if available)**:** |
| **Date of Birth:** | **Patient HCN** *(include Version Code)***:** |
| **Address:** | **Postal Code:** |
| **Phone Number:** | **Email:** |
| **Allergies:** | **OR ☐ No known allergies** |

## SECTION B: PAXLOVID Eligibility Assessment

**Part I – Patient must have a positive COVID+ diagnosis (PCR or RAT or ID NOW) and within 5 days of symptom onset**

| | |
|---|---|
| **Date of Symptom Onset:** | **Date of Positive Test:** |

**Test Type**: ☐ PCR Test ☐ Rapid Antigen Test ☐ Rapid Molecular Test (e.g. ID NOW)

**Please select the eligibility criteria the patient meets:**

**☐ Immunocompromised individuals ≥ 18 years old**

- ☐ Active Hematologic malignancy or post cell therapy (allogeneic/autologous bone marrow transplant, CAR-T cell therapy in last 6 months)
- ☐ Solid Organ or blood stem cell Transplant (_____)
- ☐ Significant immunosuppression (Please indicate type):
  - ☐ High-dose corticosteroids > 2 weeks
  - ☐ Alkylating agents
  - ☐ Antimetabolites
  - ☐ Myelosuppressive anti- cancer chemotherapy
  - ☐ TNF inhibitors
  - ☐ Anti-CD20 agents and other immunosuppressive biologic agents including for GVHD)
- ☐ Primary immunodeficiency
- ☐ Advanced or untreated HIV

**☐ High risk of hospitalization based on risk factors or inadequate immunity)**

- ☐ Age ≥60
- ☐ Age 18–59 who have one or more comorbidity that puts them at higher risk of severe COVID-19 disease:
  - ☐ Cerebrovascular disease
  - ☐ Chronic kidney disease (eGFR <60 mL/min)
  - ☐ Chronic liver disease (limited to: cirrhosis, non-alcoholic fatty liver disease, alcoholic liver disease, and autoimmune hepatitis)
  - ☐ Chronic lung diseases (limited to: bronchiectasis, chronic obstructive pulmonary disease, interstitial lung disease, pulmonary hypertension, pulmonary embolism)
  - ☐ Cystic fibrosis
  - ☐ Diabetes mellitus, type 1 and type 2
  - ☐ Disabilities (e.g. Down syndrome, learning, intellectual, or developmental disabilities; ADHD; cerebral palsy; congenital disabilities; spinal cord injuries)
  - ☐ Heart conditions (e.g., cardiomyopathies, coronary artery disease, heart failure, etc.)
  - ☐ Mental health disorders (limited to: mood disorders, including depression; schizophrenia spectrum disorders)
  - ☐ Obesity (BMI >/= 30 $kg/m^2$)
  - ☐ Pregnancy and recent pregnancy
  - ☐ Smoking, current or former
  - ☐ Tuberculosis
- ☐ Age 18–59 with inadequate immunity, i.e.:
  - ☐ Unvaccinated or incomplete primary series
  - ☐ Completed primary series AND last COVID-19 vaccine dose was 6+ months ago AND last SARS-CoV-2 infection was 6+ months ago

☐ Patient does not meet above eligibility criteria, but treatment determined appropriate (please provide reasoning):

**Part II: Best possible medication list and Drug-Drug Interactions Review for PAXLOVID**

*Please refer to the Paxlovid: What Prescribers and Pharmacists Need to Know document to review contraindications*

| | |
|---|---|
| **Retail Pharmacy Name** (if known, will be used for the purposes of med review)**:** | **Phone Number:** |

| **Please list ALL Current Medications below (or attach a list or screen shot with this form):** | |
|---|---|
| Prescription Medications (Drug Name, Dose and Frequency): | Herbals: |

*Note: A pharmacist will validate the medication list and drug-drug interaction(s) once the form is submitted and consult as required.*

**Part III: Renal & Liver Impairment**

- If eGFR < 30 ml/min, PAXLOVID can be used, a dose adjustment is required. If eGFR >30 to <60mL/min, dose adjustment is required for moderate renal impairment. An eGFR within the last 3 months is recommended. If an eGFR is not available, please assess patient for risk factors associated with reduced kidney function (diabetes, recent surgery, hypertension, etc.)
- If receiving dialysis treatment - on days of treatment, PAXLOVID is to be administered *after* treatment. Please refer to *Nirmatrelvir/Ritonavir (Paxlovid) and Remdesivir Use in Patients on Dialysis with COVID-19*
- PAXLOVID is NOT recommended in severe hepatic impairment (Child-Pugh Class C)

| | |
|---|---|
| **Patient eGFR Level** | ☐ eGFR ≥ 60 mL/min ☐ eGFR ≥30 to <60mL/min ☐ eGFR <30 mL/min |
| **Liver Function** | ☐ Severe hepatic impairment (Child-Pugh Class C) |

## SECTION C: PAXLOVID Prescription

**Dispense and Additional Instructions:**

☐ PAXLOVID 300/100 mg bid x 5 days (eGFR ≥ 60 ml/min or no risk factors)
☐ PAXLOVID 150/100 mg bid x 5 days (eGFR between 59 ml/min to 30 ml/min)
☐ PAXLOVID _____

**Dose Adjustments (please list ALL medications being held or adjusted below):**

Hold _____ for _____ days from starting PAXLOVID

Note: This prescription is to only start PAXLOVID and not intended for any other medications. Please fill out a separate prescription if your patient requires additional medications.

## SECTION D: Follow Up Monitoring

| | |
|---|---|
| Request for patient to receive follow up virtual care from the UHN Connected COVID Care Clinic:<br>• If yes, please note patient will receive an MD/NP virtual visit on Day 4 of treatment<br>• If required, please provide the patient with appropriate lab requisition and direction for follow-up tests (i.e. liver enzymes) at the time of prescription | ☐ Yes ☐ No |
| **Patient Consent - Please Ask:** For the purposes of quality improvement, the information captured on this form will be entered into a registry. You may choose to opt out of the registry. Your care in the clinic will not be affected in any way. Do you consent? | ☐ Yes ☐ No |

## SECTION E: Prescriber Attestation & Contact Information*

☐ **I affirm that the patient meets the above criteria for use and appropriate assessment has been completed.**

| | |
|---|---|
| **Physician/NP Name:** | **CPSO#:** |
| **Signature:** | **Date:** |
| **Email:** | **Phone Number:** |

*Please be available by phone or email after submitting this form for consultation in order to not delay the initiation of treatment

| SECTION F: Medication Review [PHARMACIST TO COMPLETE] | |
|---|---|
| ☐ Validate Medication List ☐ Drug-Drug Interactions Review<br>Notes: | |
| **Name:** | **Date:** |
| **Signature:** | **Phone Number:** |

Form updated: December 15, 2022