COVID-19 PAXLOVID (Nirmatrelvir/Ritonavir)Treatment Referral

Mississauga Medical Arts, 5010 Glen Erin Dr, Mississauga, L5M 6J3, 905 288 5900, www.COVIDINFO.ca

DUE TO THE VOLUME OF REFERRALS, IT MAY NOT BE POSSIBLE TO ACCOMMODATE YOUR REQUEST FOR AN APPOINTMENT IN THE REQUIRED 5 day TREATMENT TIMEFRAME.

UNTIL YOUR PATIENT IS ASSESSED AT THE CLINIC, PLEASE ENSURE THAT ADEQUATE CARE IS IN PLACE AND A FOLLOWUP IS SCHEDULED.

ALL FIELDS MUST BE FILLED FOR A REFERRAL TO BE CONSIDERED

Patient Information
Last Name: _____ First Name_____ Sex: ☐M ☐ F ☐ Other
Date of Birth: _____ Allergies: _____
Address: _____ City/Province: _____
Postal Code: _____ Phone: _____ HCN: _____

AGE:

START DATE OF SYMPTOMS (MUST BE LESS THAN 4 DAYS AGO):_____
DATE OF COVID POSITIVE TEST: _____

MOST RECENT eGFR:_____ Date of eGFR:_____

NUMBER OF COVID VACCINES: ☐ 0 ☐ 1 ☐2 ☐3 or more

All Current MEDS:

PAST MEDICAL HISTORY:

PLEASE ENSURE THAT YOUR PATIENT WANTS TO CONSIDER PAXLOVID PRIOR TO REFERRAL

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Note: Indicated for mildly ill Covid-19 patients (not on supplemental oxygen) who are at higher risk of progression to moderate or severe disease. In order to qualify for therapy, patients need to be a) within 5 days of symptom onset and b) meet one criterion listed below.

Criteria for Use – Patient should be over age 18 (All fields much be completed to be eligible for treatment)

At least one criterion below: 1) Immunocompromised OR 2) Does this individual have risk factors AND vaccine status that fits criteria below? (fill out table and check off all relevant risk factors if patient meets criteria)

1) Immunocompromised Individuals with expectation for 1-year survival prior to SARS-CoV-2 infection and with at least one of the following:

- ☐ Receipt of treatment for solid tumors and hematologic malignancies (including individuals with lymphoid malignancies who are being monitored without active treatment)
- ☐ Receipt of solid-organ transplant AND taking immunosuppressant therapy
- ☐ Receipt of chimeric antigen receptor (CAR)-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- ☐ Moderate or severe primary immunodeficiency (e.g. DiGeorge syndrome, Wiskott-Aldrich syndrome, common variable immunodeficiency, Good's syndrome, hyper IgE syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high dose corticosteroids (i.e. ≥ 20 mg prednisone or equivalent per day for at least ≥2 weeks)
- ☐ Receiving alkylating agents, antimetabolites, transplant-related immunosuppressant drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

2)	**Number of Vaccines**		
Age	***0 doses***	***1 or 2 doses***	***3 doses or 4 doses***
18-59	☐ **Eligible if** ≥ 1 risk factors	☐ **Eligible if** ≥ 1 risk factors	Not Eligible
60-69	☐ **Eligible**	☐ **Eligible**	Not Eligible
≥ 70	☐ **Eligible**	☐ **Eligible**	☐ **Eligible**
Pregnancy	☐ **Eligible**	Not Eligible	Not Eligible

RISK FACTORS:

- ☐ Obesity (BMI ≥ 30 kg/m^2)
- ☐ Diabetes
- ☐ Heart disease, HTN, congestive heart failure
- ☐ Chronic respiratory disease, including cystic fibrosis
- ☐ Cerebral palsy
- ☐ Intellectual or developmental disability
- ☐ Sickle cell disease
- ☐ Moderate or severe kidney disease (eGFR≤60mL/min)
- ☐ Moderate of severe liver disease (e.g., Child's Pugh Class B or C cirrhosis

Referring Clinician Attestation (Must be checked to be eligible for treatment)

☐ I affirm that the patient meets above criteria for treatment with PAXLOVID (Nirmatrelvir/Ritonavir)

Please attach the <u>patient's medication list</u> and/or <u>pharmacy information</u> if available: _____

MD/NP Name (print): _____ **Direct Contact number** (not office line): _____

MD/NP Signature: _____ Date/Time: _____ / _____ CPSO: _____

FAX to: 289-726-2525.

Updated April 11, 2022