Patient Information/Sticker

REFERRAL for Nirmatrelvir / Ritonavir (Paxlovid®)

Fax to 519-749-6816

Height (cm)	Weight (kg)	Allergies:

Exclusions

(if any one criteria is met, patient does NOT qualify for therapy. Do not refer for prescription)

- ☐ On dialysis or eGFR less than 30 mL/min
- ☐ Pregnancy
- ☐ Greater than 5 days of symptoms
- ☐ Unwilling to take COVID therapy

Inclusions: must meet criteria to proceed with treatment

Date of positive COVID test: _____/_____/_____ Test: ☐ RAT ☐ PCR ☐ ID NOW ☐ Pending ☐ Not done

Date of symptom onset (must be ≤5 days): _____/_____/_____

Meets Tier One OR Tier Two criteria as specified below

Tier ONE patients that qualify for therapy

Immunocompromised (over 18 years) regardless of vaccine status.

- ☐ Solid organ or bone marrow transplant
- ☐ CAR T-cell therapy
- ☐ Anti-CD 20 agent
- ☐ Alkylating agents, anti-metabolites
- ☐ Advanced or untreated HIV
- ☐ Congenital immunodeficiency
- ☐ Anti-TNF blockers or other biologic agents
- ☐ Taking chronic oral corticosteroid (greater than 20mg/d prednisone equivalent for > 2 weeks)

OR

- ☐ Unvaccinated AND:
- ☐ Age 70 years or greater
- ☐ First Nations, Inuit, Metis and age 60 yrs or greater
- ☐ Age 60 years or greater with 1 or more risk factors:
  - ☐ Diabetes
  - ☐ BMI greater or equal to 30
  - ☐ Cerebral palsy
  - ☐ Intellectual disability of any severity
  - ☐ Sickle cell disease
  - ☐ Receiving other active cancer treatment not included in immunocompromised list

Tier TWO patients that qualify for therapy

- ☐ Unvaccinated AND:
  - ☐ Age 60 years or greater
  - ☐ First Nations, Inuit, Metis and age 50 years or greater
  - ☐ Age 50 years or greater with 1 or more risk factors:
    - ☐ Diabetes
    - ☐ BMI greater or equal to 30
    - ☐ Cerebral palsy
    - ☐ Intellectual disability of any severity
    - ☐ Sickle cell disease
    - ☐ Receiving other active cancer treatment not included in immunocompromised list

Nirmatrelvir / Ritonavir Eligibility Assessment:

Note pharmacist will review eligibility, assess drug interactions and confirm dosing prior to releasing the medication.
Failure to provide this information will delay timely assessment for therapy.

- ☐ Attach current medication list including any herbal products / nutraceuticals (include drug, dose, and frequency)
- ☐ Patient's home pharmacy/phone number: _____
- ☐ Existing liver impairment: YES NO UNKNOWN
- ☐ Existing renal impairment: YES NO UNKNOWN
- ☐ If yes or unknown to liver or renal impairment:
  - ☐ Attach the most recent renal function (SCr or eGFR), bilirubin, albumin, and INR results
  - ☐ Ascites (circle one): absent slight moderate/difficult to control
  - ☐ Encephalopathy (circle one): none Grade 1-2 Grade 3-4

By referring the patient and if medication is prescribed, the referring provider assumes responsibility for all follow up based on any discharge instructions from the SMGH assessment / treatment clinic.

Physician (Print Name) _____ Physician Signature _____ Date _____

Physician Phone Number and Fax Number: _____