Referral for Outpatient Remdesivir for COVID-19

Last Updated: April 28, 2023

EMAIL COMPLETED FORM TO: COVIDCare@uhn.ca or fax **416-340-4135**

Referral form may not be processed if all sections are not completed.

IMPORTANT: In order to qualify for start of treatment, patients need to a) Be within 7 days of symptom onset b) Meet criteria for use c) Be willing to travel to the clinic (three consecutive days).

Patient Demographics & History		
Full Name:	**MRN** (if available)**:**	
Date of Birth:	**Patient HCN** *(include Version Code)***:**	
Address:		
Phone Number:	**Email:**	
Allergies:		**OR ☐ No known allergies**
Brief medical history & current medication list (prescription, non-prescription, over the counter and herbal) *Where applicable, documentation with this information can be attached*	☐ Documentation attached ☐ Patient reviewed for drug-drug interactions	

Criteria for Use	
Date of Symptom Onset:	**Date of Positive Test:**
Test Type: ☐ PCR Test ☐ Rapid Antigen Test ☐ Rapid Molecular Test	
Please select the eligibility criteria the patient meets:	
☐ Immunocompromised individuals ≥18 (regardless of vaccination status). Please specify:	**☐ High risk of hospitalization based on age, number of COVID-19 vaccine doses and risk factors. Please specify:**
☐ Active Hematologic malignancy or post cell therapy (allogeneic/autologous bone marrow transplant, CAR-T cell therapy in last 6 months) ☐ Solid Organ Transplant (Organ:_____) ☐ 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	0 doses ☐ Age < 20 AND has ≥ 3 risk factors* ☐ Age 20 to 39 AND has ≥ 3 risk factors ☐ Age 40 to 69 AND has ≥ 1 risk factors ☐ Age ≥ 70 ☐ Pregnancy 1 or 2 doses ☐ Age ≥ 20 to 69 AND has ≥ 3 risk factors ☐ Age ≥ 70 AND has ≥ 1 risk factors 3 doses ☐ Age ≥ 70 AND has ≥ 3 risk factors **Please specify risk factors:** ☐ Obesity (BMI >/= 30 kg/m^2) ☐ Diabetes ☐ Heart disease, hypertension, congestive heart failure ☐ Chronic respiratory disease, including cystic fibrosis ☐ Cerebral palsy ☐ Intellectual disability ☐ Sickle cell disease ☐ Moderate or severe kidney disease (eGFR <60 mL/min) ☐ Moderate or severe liver disease
Renal Function	**Creatinine umol/L: _____ eGFR: _____ ☐ Not Available** Please specify reason for approval:_____ (Note: no dose adjustments required for eGFR less than 30 per advisement by Infectious Diseases physicians)

Patient Demographics & History					
Full Name:			**Date of Birth:**		
Patient HCN *(include Version Code)*:					
Criteria for Use (cont'd)					
Liver Function	**ALT:**	**ALP:**	**Bili:**	**Date:**	☐ **Not Available**
	INR:	**Date:**	☐ **Not Available**		
Complex patient requiring consultation by ID:	☐ Yes ☐ N/A	If yes, ☐ Documentation attached ID Physician Consulted:			
Patient willing to travel to receive treatment (three consecutive days):		☐ Yes ☐ No			
Request for patient to receive follow up care from the COVID Care Clinic post-Remdeisivr treatment:		☐ Yes ☐ No			

Remdesivir Prescription

Remdesivir Prescription (no dose adjustments required for eGFR less than 30 per advisement by Infectious Diseases physicians):

☐ Remdesivir 200mg IV day 1, followed by Remdesivir 100mg, IV on Day 2 and Remdesivir 100mg, IV on Day 3

☐ Remdesivir 100mg IV on Day 2 and Remdesivir 100mg IV on Day 3 (day 1 already completed)

☐ IV Remdesivir _____

NOTE: Administer Remdesivir per institution/clinic policy. No refills. Remdesivir must be given over three consecutive days, unless otherwise indicated.

Dose Adjustments (please note if there are any medications being held or adjusted below):

Hold _____ for _____ days from starting Remdesivir

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

Administration Orders

☐ Insert saline lock and keep for 3 days for Remdesivir treatment, discontinue saline lock after treatment is complete

Prescriber Attestation

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

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