Referral for Outpatient Remdesivir for COVID-19

Last Updated: February 2, 2024

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 able to receive three days of consecutive IV therapy in clinic (in home, by exception).

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**
Patient has a history of serious adverse or allergic reaction to the prescribed medication or related compound?	☐ Yes ☐ No
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	
Prescriber acknowledges Ontario Health (OH) & MOH guidelines have been met:	☐ Yes ☐ No
Please select the eligibility criteria the patient meets:	
☐ **Adults ≥60 years of age with no other risk factors (regardless of vaccination status)**	
☐ **Adults with one or more underlying conditions that puts them at high risk for severe COVID-19 outcomes**	
☐ **Immunocompromised adults ≥18 (regardless of age, vaccination status, or prior infections).** Examples: • active hematological malignancy or post stem cell transplant or CAR T-cell therapy in last 6 months • solid organ transplant • hypogammaglobulinemia • taking prednisone greater than 20 mg/day (or equivalent) for more than 14 days • other moderately or severely immunosuppressive therapies (example: anti-CD20 agents, alkylating agents, cancer chemotherapy)	☐ **Adults with inadequate immunity, such as:** • Unvaccinated or under-vaccinated (example: completed primary series AND last COVID-19 vaccine dose was more than 6 months ago AND last SARS-CoV-2 infection was more than 6 months ago). • See the most recent immunization guidance from National Advisory Committee on Immunization to determine if your patient is under-vaccinated.
Renal Function	**Creatinine umol/L: _____ eGFR: _____ ☐ Not Available** Please specify reason for approval:_____ (Note: no dose adjustment required with impaired renal function, including patients on dialysis)

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		
For patients receiving a First Dose					
Is patient on beta-blockers?			☐ Yes ☐ No		
Please note: as per the latest OH guidelines, there are no contraindications for patients on beta blockers and the benefit of Remdesivir treatment outweighs the risk					

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 on date and time:

☐ 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:**