The Ottawa Hospital

COVID-19 THERAPEUTICS PROVIDER ASSESSMENT FORM

Fax completed referral forms to 613-739-6751. Information must be complete and accurate to ensure timely access to therapy.

PATIENT INFORMATION		
Name:	Sex: ❑ M ❑ F ❑ Other:	Date of Birth (DD/MM/YY):
Allergies:	Height (cm):	Weight (kg):
Address:	City:	Province:
Postal Code:	Phone:	HCN:
Pregnant: ❑ Y ❑ N Breastfeeding: ❑ Y ❑ N	Serum Creatinine:	Pharmacy Name: Pharmacy Phone:

Criteria for Use (all fields must be completed to be eligible for treatment)	
Patient History:	
Date of symptom onset:	
Symptoms:	
Date of positive COVID-19 test:	
Preferred Remdesivir infusion location:	❑ TOH Infusion Clinic ❑ TOH Dialysis ❑ Other infusion site ________________________
Attach medication list (including nonprescription medications, supplements, vitamins and/or herbals)	❑ Attached ❑ Reviewed for drug-drug interactions

❑ **CRITERIA 1:** Immune suppressed (regardless of vaccine status)

❑ Treatment of Solid Organ Cancer	❑ Lymphoma	❑ Hematologic malignancy
❑ Receipt of CAR-T therapy	❑ Bone Marrow Transplant	❑ Solid Organ Transplant
❑ Congenital Immunodeficiency (please specify)	❑ Corticosteroids (> 20mg prednisone per day for > 2 weeks)	❑ Oral immunosuppressive agents: (please specify)
❑ Biologic agents (Please specify)	❑ Untreated or advanced HIV	❑ Other immunosuppressing condition:

❑ **CRITERIA 2:** Pregnant AND unvaccinated?

❑ **CRITERIA 3:** Does this individual have risk factors AND vaccine status that fits criteria below? (please check risk factors in a) and fill out table b if patient meets criteria)

a) Risk Factors – please check all that apply

❑ Obesity	❑ Cerebral Palsy	❑ Kidney Disease (GFR < 60 ml/min)
❑ Diabetes	❑ Intellectual Disability	❑ Liver Disease (CP Class B/C)
❑ Heart Disease (CAD, HTN, or CHF)	❑ Sickle cell Disease	❑ Respiratory Disease

b) Vaccine Status and Risk factors (Please check if the patient fits an eligible category)

Age	**Number of Vaccine Doses**		
	0 doses	**1 or 2 doses**	**3 doses**
<20	❑ Eligible if 3 or more risk factors	Not eligible	Not eligible
20-39	❑ Eligible if 3 or more risk factors	❑ Eligible if 3 or more risk factors	Not eligible
40-69	❑ Eligible if 1 or more risk factors	❑ Eligible if 3 or more risk factors	Not eligible
>70	❑ Eligible	❑ Eligible if 1 or more risk factors	❑ Eligible if 3 or more risk factors

PRESCRIBER ATTESTATION		
❑ I affirm that my patient meets above criteria for use		
Prescriber Name (print):	Direct Contact Number (not office line)	
Prescriber Signature:	Date/Time:	College #:

The Ottawa Hospital

COVID-19 OUTPATIENT PAXLOVID TREATMENT PRESCRIPTION

Fax completed referral forms to 613-739-6751.
NOTE: The patient will be triaged to receive the most appropriate therapy. In the event that Paxlovid is chosen, please complete the following prescription in advance:

PATIENT INFORMATION		
Name:	Date of Birth (DD/MM/YY):	
Address:	City:	Province:
Postal Code:	Phone:	HCN:

PLEASE SELECT FOR NORMAL RENAL FUNCTION (GFR ≥ 60mL/min) ❑

PAXLOVID (Nirmatrelvir 150mg tablet/Ritonavir 100mg tablet)

Sig: Take two tablets of Nirmatrelvir 150mg by mouth and one tablet of Ritonavir 100mg by mouth twice daily for five days

Mitte: Twenty tablets of Nirmatrelvir 150mg and ten tablets of Ritonavir 100mg

Refills: None

PLEASE SELECT FOR REDUCED RENAL FUNCTION (30mL/min ≤ GFR < 60mL/min) ❑

PAXLOVID (Nirmatrelvir 150mg tablet/Ritonavir 100mg tablet)

Sig: Take one tablet of Nirmatrelvir 150mg by mouth and one tablet of Ritonavir 100mg by mouth twice daily for five days

Mitte: Ten tablets of Nirmatrelvir 150mg and ten tablets of Ritonavir 100mg

Refills: None

Prescriber Name (print):	Direct Contact Number (not office line)	
Prescriber Signature:	Date/Time:	College #:
Prescriber Address:		