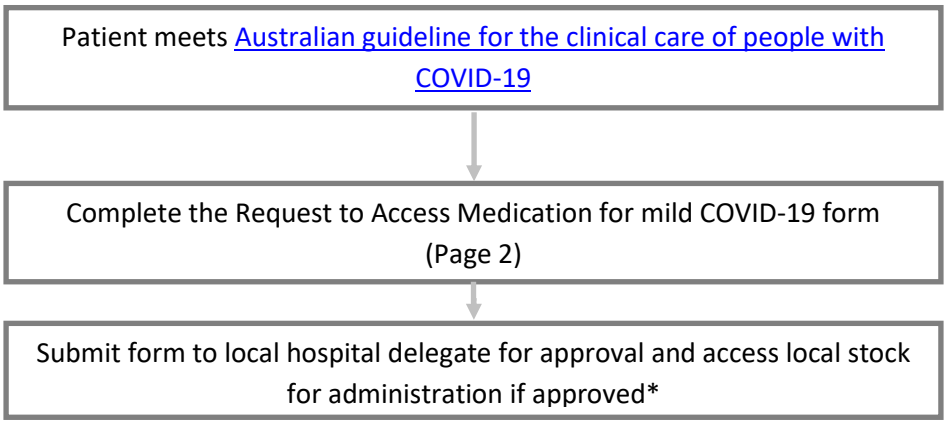
REQUEST TO ACCESS
MEDICATION FOR MILD COVID-19

- A streamlined approach has been developed to assist access to Remdesivir, Sotrovimab, Ronapreve (casirivimab plus imdevimab), Paxlovid (nirmatrelvir plus ritonavir) and Lagevrio (molnupiravir) for mild COVID-19
- Remdesivir, Sotrovimab, Ronapreve, Paxlovid and Lagevrio are only available for patients who meet the criteria listed on page 2.
- Access to stock will require completion of the Request to Access Medication for mild COVID-19 Form (page 2) by the prescriber and must fulfil all required criteria.



***NOTE:** Stock will be supplied by Alfred Pharmacy and organised by the local hospital pharmacy department for approved patients

References

1) Australian guideline for the clinical care of people with COVID-19
2) Pathways to care for adults with COVID-19
3) Management of adults with mild COVID-19
4) Ronapreve product information
5) Sotrovimab (Xevudy) product information
6) Paxlovid product information
7) Lagevrio product information
8) Remdesivir product information

REQUEST TO ACCESS
MEDICATION FOR MILD COVID-19

PATIENT DETAILS

Patient Initials _____ Patient MRN _____

Patient DOB (dd/mm/yyyy) _____ Hospital _____

Sex
- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Not disclosed

Current patient location
- ☐ Hospital inpatient (excluding HITH)
- ☐ ED
- ☐ HITH
- ☐ Home
- ☐ Other: _____

ACCESS CRITERIA (tick each criterion that applies)

MUST MEET ALL (Age ≥ 18 years, or aged ≥12 and <18 years of age and weighing ≥40kg):

☐ Confirmed SARS-CoV2

☐ No oxygen requirements

SYMPTOM ONSET AND DRUG INFORMATION (also complete patient access group section below)

Date of symptom onset: _____

☐ Day 0-5 from symptom onset:
- ☐ Nirmatrelvir and ritonavir (Paxlovid) (*Use of form optional)*
- ☐ Molnupiravir (Lagevrio) (*Use of form optional*)
- ☐ Sotrovimab (Xevudy). Planned location of administration_____

☐ Day 0-7 from symptom onset: Remdesivir (Veklury).

☐ Day 6-7 from symptom onset: Ronapreve. Planned location of administration_____

S/C (4X2.5ml injection) ☐ IV ☐

PATIENT ACCESS GROUP

Patient Access Group	Eligibility Criteria	Section to complete	
≥70	All eligible including if asymptomatic (Irrespective of vaccination status)		☐
≥50	If not up-to-date with vaccinations		☐
Pregnant (> 13 weeks)	If not up-to-date with vaccinations		☐
≥18	COVID+ patients in an outbreak setting (Irrespective of vaccination status)		☐
≥12	Must have at least one immunosuppressive condition (*Refer table below)*	Immunosuppressive Condition	☐
≥12	Must have at least one risk factor (*Refer table below*)	Risk Factor	☐

OTHER- In exceptional circumstances, access to COVID-19 medications may be considered for patients who do not fit within the eligibility requirements. In these cases, the medication can be accessed if the patient's case has been discussed with two senior physicians (at least one of which is an infectious disease physician where available) and there is consensus that the treatment is clinically indicated.
Please provide a summary of the exceptional circumstances:

ID Physician Name_____ Senior Medical Practitioner Name_____

IMMUNOSUPPRESSIVE CONDITION (Please complete if specified in table above)

Refer to Department of Health website for further detail

Any primary or acquired immunodeficiency, including:

- ☐ **a.** Haematologic neoplasms: leukaemias, lymphomas, myelodysplastic syndromes, multiple myeloma and other plasma cell disorders,
- ☐ **b.** Post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months),
- ☐ **c.** Immunocompromised due to primary or acquired (HIV/AIDS) immunodeficiency

Any significantly immunocompromising condition(s) where, in the last 3 months the patient has received:

- ☐ **a.** Chemotherapy or whole body radiotherapy
- ☐ **b.** High-dose corticosteroids (at least 20 mg of prednisone per day, or equivalent) for at least 14 days in a month, or pulse corticosteroid therapy
- ☐ **c.** Biological agents and other treatments that deplete or inhibit B cell or T cell function (abatacept, anti-CD20 antibodies, BTK inhibitors, JAK inhibitors, sphingosine 1-phosphate receptor modulators, anti-CD52 antibodies, anti-complement antibodies, anti-thymocyte globulin)
- ☐ **d.** Selected conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDs) including mycophenolate, methotrexate, leflunomide, azathioprine, 6-mercaptopurine (at least 1.5mg/kg/day), alkylating agents (e.g. cyclophosphamide, chlorambucil), and systemic calcineurin inhibitors (e.g. cyclosporin, tacrolimus)
    - ☐ Any significantly immunocompromising condition(s) where, in the last 12 months the patient has received rituximab
    - ☐ Others with very high-risk conditions including Down Syndrome, cerebral palsy, congenital heart disease, thalassemia, sickle cell disease and other haemoglobinopathies
    - ☐ The patient has disability with multiple comorbidities and/or frailty

RISK FACTORS (Please complete if specified in table above)

High-risk comorbidities

- ☐ The patient is in residential aged care
- ☐ The patient has disability with multiple comorbidities and/or frailty
- ☐ Neurological conditions, including stroke and dementia and demyelinating conditions
- ☐ Respiratory compromise, including COPD, moderate or severe asthma (required inhaled steroids), and bronchiectasis, or caused by neurological or musculoskeletal disease
- ☐ Heart failure, coronary artery disease, cardiomyopathies

- ☐ Obesity (BMI greater than 30 kg/m2)
- ☐ Diabetes type I or II, requiring medication for glycaemic control
- ☐ Renal impairment (eGFR < 60mL/min)
- ☐ Cirrhosis
- ☐ The patient has reduced, or lack of, access to higher level healthcare and lives in an area of geographic remoteness classified by the Modified Monash Model as Category 5 or above
- ☐ Paediatric complex chronic conditions (PCCC)

PRESCRIBER DETAILS

Prescriber Full Name _____ Prescriber Email _____

Prescriber Job Title _____ Phone Number _____

- ☐ I declare that the above information is accurate at the time of completion and agree to provide patient outcome information when requested by the Victorian Department of Health.
- ☐ I declare that patient consent for treatment with Sotrovimab, Remdesivir, Ronapreve®, molnupiravir or nirmatrelvir and ritonavir has been obtained.
- ☐ I declare the location of administration fulfils the Department of Health requirements.

Please EMAIL the completed request form to:

1) The nominated hospital pharmacy delegate for your hospital _____

AND (for only Remdesivir, Sotrovimab or Ronapreve):

2) pharmdist@alfred.org.au