

[PLACE PATIENT LABEL HERE]

Approval Form for Critically Ill Patients with COVID-19 - Immunomodulatory Agents

Definition: Patients requiring high-flow oxygen, non-invasive ventilation (e.g. AIRVO), or requiring invasive mechanical ventilation and/or circulatory support.

COVID-19 treatment recommendations adapted from the [Ontario Science Advisory Table](#)

- Baricitinib may be considered when tocilizumab or sarilumab are not available.
- Dosing Recommendations:
 - Tocilizumab or Sarilumab 400 mg IV x 1 dose
 - Baricitinib 4 mg PO/NG/GT daily (eGFR 60 mL/min or greater) or 2 mg PO/NG/GT daily (eGFR 30-59 mL/min) or 2 mg PO/NG/GT every 2nd day (eGFR 15-29 mL/min) up to 14 days (or until discharge if sooner)
 - Avoid use in patients with absolute lymphocyte count (ALC) less than $0.2 \times 10^9/L$, absolute neutrophil count (ANC) less than $1 \times 10^9/L$ or AST/ALT greater than five times upper limit of normal
- COVID-19 therapies will be dispensed upon receipt of this completed approval form AND an accompanying order
- Prescribers must dictate a note describing the informed consent discussion and attainment of prescribing criteria

Tocilizumab, Sarilumab or Baricitinib (depending on availability)

Inclusion Criteria <i>(Note: All boxes must be checked off)</i>	YES	NO
Requiring oxygen via high flow nasal cannula (e.g. Ventimask, AIRVO), or invasive mechanical ventilation and/or circulatory support		
Dexamethasone therapy has been started but without other ongoing immunosuppression		
Referred to the Critical Care service and is deemed to be a candidate for critical care admission (Does not require patient to be physically in Critical Care Unit)		
Within 14 days of hospitalization OR within 14 days of a new COVID-19 diagnosis if nosocomial acquired (Date of Admission: _____)		

Exclusion Criteria <i>(Note: All boxes must be checked off)</i>	YES	NO
Severe hypersensitivity (e.g. anaphylaxis) to chosen therapy		
For Baricitinib eGFR less than 15 mL/min		
For Tocilizumab or Sarilumab Platelet count below $50 \times 10^9/L$		
For Tocilizumab or Sarilumab ALT or AST above five times the upper limit of normal		

COMMENTS:

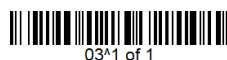
REQUIRED APPROVALS	NAME	SIGNATURE	DATE
Ordering Prescriber			
Supporting Infectious Disease Physician <u>OR</u> Intensivist (ICU or CCRT)			



01*ORDER



02*8700-010



03* of 1



04*NoRxCode