(Nirmatrelvir-Ritonavir) Paxlovid™ Prescription

☐ MUST include accurate medication list with Form

Please fax completed form AND patient's medication list to patient's preferred pharmacy

Prescriber Information		**Patient Information**			
First Name	**Last Name**	**First Name**	**Last Name**	**Sex (at birth)** ☐ Male ☐ Female	**DOB**
Address		**Address**		**Health Card No.**	**Version**
		City		**Postal Code**	
City	**Postal Code**	**Telephone**		**Preferred Language** ☐ EN ☐ Other	
Telephone	**Fax**	**Height (cm)**		**Weight (Kg)**	

INCLUSION CRITERIA: MUST MEET CRITERIA TO PROCEED WITH TREATMENT

Date of positive COVID test: **Date of symptom onset (must be 5 days or less):**

AGE (YEARS)	**NUMBER OF VACCINE DOSES**	
	0, 1, OR 2 DOSES	**3 DOSES**
18 to 59	**Eligible if 1 or more risk factors**	**Not Eligible**
60 to 69	**Eligible**	**Not Eligible**
70 or greater	**Eligible**	**Eligible**
Immunocompromised individuals of any age (18 years of age and older)	**Eligible: Therapeutics should always be recommended for immunocompromised individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying immune status, regardless of age or vaccine status.**	
Pregnancy	**0 DOSES**	**1,2, OR 3 DOSES**
	Eligible	**Not Eligible**

Indigenous persons (First Nations, Inuit, or Métis), Black persons, and members of other racialized communities may be at high risk of disease progression due to disparate rates of comorbidity, increased vaccination barriers, and social determinants of health, and should be considered priority populations for access to COVID-19 therapeutics.

Risk Factors: (Check all that apply)

- Obesity (BMI greater than or equal to 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 less than 60 ml/min)
- Moderate or severe liver disease (e.g. Child-Pugh Class B or C)

*** Evidence for less than 18 years of age is limited. Multidisciplinary consultation with infectious diseases and primary care is recommended**

Immunocompromise Factors: (Check all that apply)

- Solid organ or bone marrow transplant **(*)**
- CAR T-cell therapy
- Anti-CD 20 agent
- Alkylating agents, anti-metabolites **(*)**
- Advanced or untreated HIV
- Congenital immunodeficiency
- Anti-TNF blockers or other biologic agents **(*)**
- Taking chronic oral corticosteroid (greater than 20mg/d prednisone equivalent for greater than 2 weeks)
- Other: Name of Immune modifying Drug _____

(*) Depending on absolute contraindications

Note: These individuals should have a reasonable expectation for 1-year survival prior to SARS-COV-2 infection

(Nirmaltrevir-Ritonavir) Paxlovid™ Assessment:

- Attach current medication, herbal, OTC list
- Patient's home pharmacy
- Home pharmacy phone number
- Allergies ☐ NKA

Is the patient pregnant? ☐ YES ☐ NO ☐ N/A

Existing liver impairment: ☐ YES ☐ NO ☐ UNKNOWN

Existing renal impairment: ☐ YES ☐ NO ☐ UNKNOWN

If YES, enter Serum Creatinine and eGFR if available

- Serum Creatinine (µmol/L):_____ _ Date:_____
- eGFR (ml/min): Date:

Note pharmacist will review eligibility, assess drug interactions and confirm dosing prior to releasing the medication. Any recommended changes to the therapeutic regimen will be communicated back to the prescriber.

Medication Order

Standard Dose (eGFR above 60ml/min)

- Paxlovid (Nirmatrelvir 150mg and Ritonavir 100mg): Take 2 pink tablets of nirmatrelvir and 1 white tablet of ritonavir once in the morning and once in the evening for 5 days

Reduced Dose (eGFR between 30-59ml/min)

- Paxlovid (Nirmatrelvir 150mg and Ritonavir 100mg): Take 1 pink tablet of nirmatrelvir and 1 white tablet of ritonavir once in the morning and once in the evening for 5 days

By prescribing this medication, the referring prescriber assumes responsibility for all follow up.

Physician/NP Registration Number _____ Signature _____ Date _____