**For Oral Antivirals (Paxlovid & Molnupiravir)**

Fax the following information to 617-414-6628:

* Prescriptions (or e-prescribed into the BMC Yawkey pharmacy)
* Referral form
* Medication list

*Delivery available within one business day if patient can be contacted via contact information provided above to verify address.*

**For IV antivirals (Remdesivir):**

* Email this form to [covidinfusion@bmc.org](mailto:covidinfusion@bmc.org)

**Yawkey Pharmacy 850 Harrison Ave**

**Boston, MA 02118**

**Ph: 617.414.4883**

**Fax: 617.414.6628**

BMC Referral Form for Antiviral & Remdesivir Antibody Treatment for COVID-19 Infection

|  |  |
| --- | --- |
| **Patient Information** | |
| **Name: Date of birth: Sex: M / F / X**  **Address: Phone:**  **Allergies: Weight:** | |
| **Patient Demographics:**  **Race: Hispanic:** Yes/No   * American Indian or Alaska Native  Black or African American  Other Pacific Islander **Long-Term Emotional/Learning Disorder:** Yes / No * Asian  Native Hawaiian  White **Physical Disability/Long-Term Disorder:** Yes / No | |
| ***NOTE: These products are NOT authorized for use in patients hospitalized due to COVID-19; or who require oxygen therapy due to COVID-19; or who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity.*** | |
| **Non-hospitalized** patients with a **positive COVID test** and with **mild to moderate symptoms**  AND at least One of the risk factors  View the full list of CDC medical conditions at: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html> | **HOW TO SEND PRESCRIPTIONS TO BMC** |

|  |  |
| --- | --- |
| **DAYS SINCE SYMPTOM ONSET** | |
| 1-5 days | 6-7 days |
| Paxlovid  or  Remdesivir | Remdesivir |

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| **Risk factors (please also note drug-drug interactions that may warrant one medication over another):**   * **Age >65yo** (*Molnupiravir is not approved for age <18)* * **Obesity (***BMI greater than 30 kg/m2, or if age 12-17 have BMI > 85th percentile for their age & gender based on CDC growth charts,* [*https://www.cdc.gov/growthcharts/clinical\_charts.htm*](https://www.cdc.gov/growthcharts/clinical_charts.htm)) * **Pregnancy** (*Molnupiravir is contraindicated in pregnancy, & lactating mothers. A reliable method of birth control should be used consistently & correctly during treatment & for at least 3 months after the last dose for both men & women*) * **Chronic kidney disease** (*Paxlovid is contraindicated for eGFR < 30 mL/min*) * **Diabetes** * **Moderate to severe immunocompromised:** *Immunosuppressive disease or immunosuppressive treatment* * **Cardiovascular disease** (*including congenital heart disease, CHF, etc*) * **HIV+** with CD4 <200, 15% * **Chronic lung disease** (*COPD, moderate-to-severe asthma, interstitial lung disease, cystic fibrosis & pulmonary HTN*) * **Chronic liver disease (***Paxlovid is contraindicated in the presence of advanced liver disease (Child Pugh C)*) * **Neurodevelopmental disorders** (*for example, cerebral palsy or other conditions that confer medical complexity; e.g. genetic or metabolic syndromes & severe congenital anomalies*) * Having a **medical-related technological dependence** |
| **Prescriber Attestation** |
| I affirm that my patient meets the DPH criteria for oral antiviral treatment for COVID-19, does not have contraindications to the medication prescribed, and that the patient agrees to treatment. |
| **Provider Name** (print): **Provider Contact Number: Provider NPI**:  **Provider Signature/**title: **Date:** |