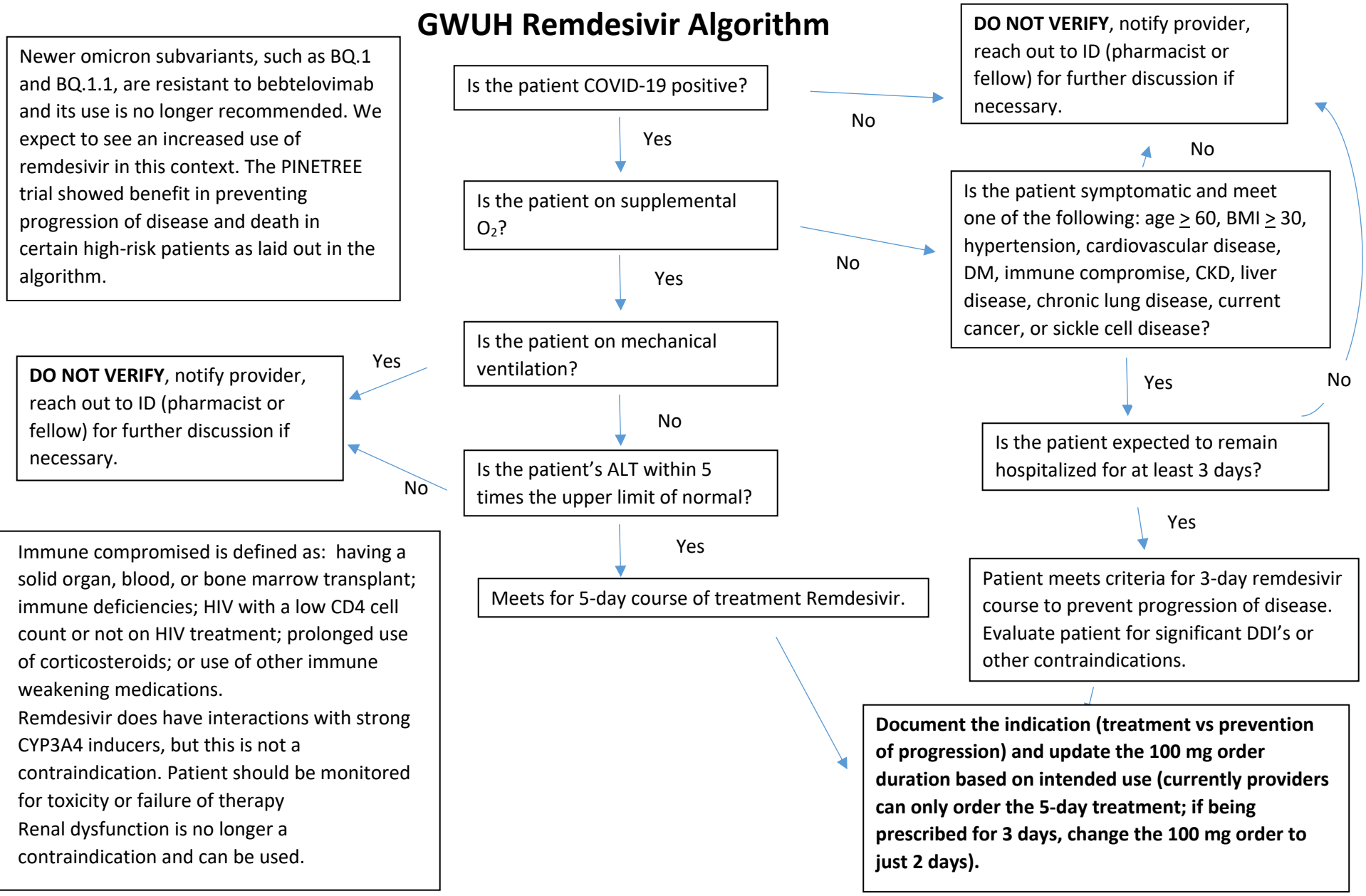
GWU Hospital Adult COVID-19 Management Guidance

Category	Recommendations	Additional Comments
A. Outpatient, asymptomatic	• Supportive Care • No medications recommended	No evidence to support therapeutic interventions in asymptomatic patients at this time
B. Outpatient, symptomatic (i.e., patients in ED who do not meet criteria for admission)	1. Nirmatrelvir/ritonavir (PAXLOVID)* 2. Molnupiravir (LAGEVRIO) * Paxlovid dose depends on renal function; multiple potential drug interactions, please reach out to pharmacy with questions. The following link can also be helpful. https://www.covid19-druginteractions.org/checker	Nirmatrelvir/ritonavir is the outpatient treatment of choice for COVID-19. Molnupiravir may be considered when Paxlovid is not clinically appropriate and when not contraindicated (i.e., pregnancy). *** Bebtelovimab is no longer recommended for use as the new omicron subvariants (i.e., BQ.1 and BQ.1.1) are resistant.**
C. Inpatient, asymptomatic or mild symptoms without oxygen supplementation, or hospitalized for non-COVID-19 reasons	• Supportive Care • Remdesivir 200mg on day 1 then 100 mg daily for 2 days* *If patient meets criteria for use	The PINETREE study demonstrated that a 3-day course of remdesivir resulted in an 87% lower risk of disease progression and death vs placebo in high-risk individuals (≥ 60 y/o, BMI ≥ 30, HTN, CVD, DM, immunocompromised, CKD, liver disease, chronic lung disease, current cancer, or sickle cell disease).
D. Inpatient with new supplemental oxygen via low-flow nasal cannula	• Supportive Care • Dexamethasone 6 mg PO (IV only if unable to take PO) for up to 10 days • Remdesivir 200 mg on day 1 then 100 mg daily for 4 days	Best evidence for clinical improvement and mortality benefit (particularly for dexamethasone). Patients do not need to stay in the hospital to complete therapy if otherwise ready for discharge.
E. Inpatient, requires supplemental oxygen via high-flow nasal cannula or non-invasive ventilation	• Recommendations as for category D • Consider ID consult for baricitinib (preferred) or tocilizumab*^ with rapidly increasing oxygen needs and systemic inflammation * See separate criteria for use for baricitinib and tocilizumab ^ Baricitinib and tocilizumab should not be given together	Same as above for remdesivir and dexamethasone. Tocilizumab has only been shown to be beneficial if started within 24 hours of rapid respiratory decompensation. No benefit has been found if tocilizumab is used without dexamethasone. Baricitinib may be beneficial in patients receiving mechanical ventilation or ECMO, but data is limited.
F. Inpatient, requires mechanical ventilation or ECMO	• Dexamethasone 6mg IV daily for up to 10 days • Recommend against remdesivir • Consider ID consult for baricitinib or tocilizumab as above	Remdesivir showed no benefit when used in patients requiring mechanical ventilation and should not be used in those patients.

Version 2.0 – Updated 11/18/2022 by Jose Lucar, MD and Matt Spence, PharmD
(Approved by GWUH ASP Committee)

GWUH Remdesivir Algorithm

Newer omicron subvariants, such as BQ.1 and BQ.1.1, are resistant to bebtelovimab and its use is no longer recommended. We expect to see an increased use of remdesivir in this context. The PINETREE trial showed benefit in preventing progression of disease and death in certain high-risk patients as laid out in the algorithm.



- Immune compromised is defined as: having a solid organ, blood, or bone marrow transplant; immune deficiencies; HIV with a low CD4 cell count or not on HIV treatment; prolonged use of corticosteroids; or use of other immune weakening medications.
- Remdesivir does have interactions with strong CYP3A4 inducers, but this is not a contraindication. Patient should be monitored for toxicity or failure of therapy
- Renal dysfunction is no longer a contraindication and can be used.

Version 1.2 – Updated 11/18/2022 by Jose Lucar, MD and Matt Spence, PharmD (Approved by GWUH ASP Committee)