SJH Treatment Guideline for Hospitalized Patients with COVID-19

Clinicians are advised that currently, there are no FDA approved regimens or regimens with strong levels of recommendation from professional societies. Clinicians must weigh risks against benefits when using the therapies listed below. **Supportive treatment remains the mainstay for treatment approaches **

Does the patient with suspected or confirmed SARS-CoV-2 meet ALL criteria for FEMA remdesivir?

Inclusion Criteria	1. Pulmonary infiltrates on imaging, or O_2 saturation ≤ 94% on room air, or Requiring supplemental oxygen 2. Adults ≥ 18 years 3. Children < 18 years AND weight > 40 kg
Exclusion Criteria	1. Remdesivir clinical trial participant or being evaluated for participation 2. Anticipated discharge within 72 hours 3. Known hypersensitivity to remdesivir or diluent cyclodextran 4. AST/ALT ≥ 5X ULN 5. GFR < 30 mL/min or hemodialysis 6. Cardiac arrest prior to or during current hospitalization 7. Advances comorbidities including: severe liver disease, severe neurologic disease/advanced dementia, advanced malignancy, functional dependency for activities of daily living due to progressive chronic comorbidities, or any conditions in which advanced life support would be futile

YES → Call 973-754-3032 for remdesivir order entry

Dosing: Remdesivir 200 mg x once followed by 100 mg Q24H for 4 doses

Emergency Use Authorization (FEMA) supply may not be used for more than 5 doses.

NO → Call 973-754-3032 for clinical trial consideration

Does the patient meet ANY of the following criteria?

1. SpO_2 ≤ 94% on room air
2. Requiring supplemental oxygen

NO → Use of glucocorticoids is NOT recommended (*Conditional recommendation, low certainty of evidence)*

YES ↓

Start a glucocorticoid
(*Conditional recommendation, moderate certainty of evidence)*

Preferred
- Dexamethasone 6 mg IV or PO daily for 10 days

Alternatives
- Methylprednisolone 40 mg IV or 32 mg PO daily for 10 days
- Prednisone 40 mg PO daily for 10 days

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Additional Agents that May be Considered for Use in COVID-19

Please note that at this time many agents are in critically low supply and have very limited data to support their use. Clinicians must weigh risks against benefits when using the therapies listed below. **Supportive treatment remains the mainstay for treatment approaches. **

Agent	Dose		Comments
Ascorbic acid	500 mg PO BID		• Use caution/avoid in patients with renal dysfunction due to accumulation • Continued use based on availability
Zinc	Zinc Gluconate 50 mg daily	Zinc Sulfate 220 mg daily	• Use caution/avoid in patients with renal dysfunction due to accumulation • Continued use based on availability

Agents NOT Recommended for Use in COVID-19

Agent	Comments
Tocilizumab	• The 9/25/20 version of the COVID IDSA treatment guidelines recommend against routine use • Trials as of 10/2020 have not shown improvement in COVID related morbidity/outcomes with tocilizumab use (possible worsening) • At this time use is not recommended outside the setting of a clinical trial
ACE inhibitors and ARB's	• Patients should NOT be started on an ACE inhibitor or an ARB for the treatment of COVID-19. • It is strongly recommended that those patients prescribed ACE inhibitors and ARBs for preexisting conditions should be continued on their ACE inhibitor and ARB therapy. • Currently, there is no scientific or clinical evidence that taking ACE inhibitors or ARBs increases the risk of acquiring COVID-19 or that use may increase the severity of illness for those acquiring infections.
Chloroquine/hydroxychloroquine ± azithromycin	• Because of uncertainty regarding the risks and benefits of this combination and potential for toxicity, use should only be in the context of a clinical trial.
Darunavir/Cobicistat (Prezcobix®)	• Due to risk of adverse events and drug-drug interactions, along with lack of data in SARS-CoV-2 at present time, not currently recommended.
Ivermectin (Stromectol®)	• Displays inhibitory activity against the virus in vitro however no clinical data in humans exists. Currently unavailable.
IVIG	• IVIG remains on critical national shortage. The benefit in patients with COVID-19 is unclear.
Lopinavir/Ritonavir (Kaletra®)	• Due to risk of adverse events and drug-drug interactions, along with lack of beneficial data in SARS-CoV-2 at present time, not currently recommended.
Nitazanoxide (Alinia®)	• Displays inhibitory activity against the virus in vitro however no clinical data in humans exists
NSAIDs	• Thought to increase the ACE2 enzyme which potentially may allow for easier entry of the virus in to the cells • Use of acetaminophen is preferred however if needed NSAIDs may be used
Oseltamivir (Tamiflu®)	• SARS-CoV-2, the virus that causes COVID-19, does not use neuraminidase as part of the viral replication cycle so oseltamvir is unlikely to be of

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	therapeutic value, and supplies should be preserved for patients with influenza.

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