

Referral for Outpatient Remdesivir for COVID-19

Last Updated: June 28, 2024

EMAIL COMPLETED FORM TO: COVIDCare@uhn.ca or fax 416-340-4135

Referral form may not be processed if all sections are not completed.

IMPORTANT: In order to qualify for start of treatment, patients need to a) Be within 7 days of symptom onset b) Meet criteria for use c) Be willing to travel to the clinic (three consecutive days).

Patient Demographics & History	
Full Name:	MRN (if available):
Date of Birth:	Patient HCN (include Version Code):
Address:	
Phone Number:	Email:
Allergies:	OR <input type="checkbox"/> No known allergies
Brief medical history & current medication list (prescription, non-prescription, over the counter and herbal) <i>Where applicable, documentation with this information can be attached</i>	<input type="checkbox"/> Documentation attached <input type="checkbox"/> Patient reviewed for drug-drug interactions
Criteria for Use	
Date of Symptom Onset:	Date of Positive Test:
Test Type: <input type="checkbox"/> PCR Test <input type="checkbox"/> Rapid Antigen Test <input type="checkbox"/> Rapid Molecular Test	
Please select the eligibility criteria the patient meets:	
<input type="checkbox"/> Immunocompromised individuals ≥18 (regardless of vaccination status). Please specify: <input type="checkbox"/> Active Hematologic malignancy or post cell therapy (allogeneic/autologous bone marrow transplant, CAR-T cell therapy in last 6 months) <input type="checkbox"/> Solid Organ Transplant (Organ: _____) <input type="checkbox"/> Significant immunosuppression (Please indicate type): <input type="checkbox"/> High-dose corticosteroids > 2 weeks <input type="checkbox"/> Alkylating agents <input type="checkbox"/> Antimetabolites <input type="checkbox"/> Myelosuppressive anti- cancer chemotherapy <input type="checkbox"/> TNF inhibitors <input type="checkbox"/> Anti-CD20 agents and other immunosuppressive biologic agents including for GVHD) <input type="checkbox"/> Primary immunodeficiency <input type="checkbox"/> Advanced or untreated HIV	<input type="checkbox"/> High risk of hospitalization based on age, number of COVID-19 vaccine doses and risk factors. Please specify: 0 doses <input type="checkbox"/> Age < 20 AND has ≥ 3 risk factors* <input type="checkbox"/> Age 20 to 39 AND has ≥ 3 risk factors <input type="checkbox"/> Age 40 to 69 AND has ≥ 1 risk factors <input type="checkbox"/> Age ≥ 70 <input type="checkbox"/> Pregnancy 1 or 2 doses <input type="checkbox"/> Age ≥ 20 to 69 AND has ≥ 3 risk factors <input type="checkbox"/> Age ≥ 70 AND has ≥ 1 risk factors 3 doses <input type="checkbox"/> Age ≥ 70 AND has ≥ 3 risk factors Please specify risk factors: <input type="checkbox"/> Obesity (BMI >= 30 kg/m ²) <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease, hypertension, congestive heart failure <input type="checkbox"/> Chronic respiratory disease, including cystic fibrosis <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Moderate or severe kidney disease (eGFR <60 mL/min) <input type="checkbox"/> Moderate or severe liver disease
Renal Function	Creatinine umol/L: _____ eGFR: _____ <input type="checkbox"/> Not Available Please specify reason for approval: _____ (Note: no dose adjustments required for eGFR less than 30 per advisement by Infectious Diseases physicians)

Patient Demographics & History					
Full Name:			Date of Birth:		
Patient HCN (include Version Code):					
Criteria for Use (cont d)					
Liver Function	ALT:	ALP:	Bili:	Date:	<input type="checkbox"/> Not Available
	INR:	Date:	<input type="checkbox"/> Not Available		
Complex patient requiring consultation by ID:	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A	If yes, <input type="checkbox"/> Documentation attached ID Physician Consulted:		
Patient willing to travel to receive treatment (three consecutive days):			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Request for patient to receive follow up care from the COVID Care Clinic post-Remdesivir treatment:			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Remdesivir Prescription					
Remdesivir Prescription (no dose adjustments required for eGFR less than 30 per advisement by Infectious Diseases physicians):					
<input type="checkbox"/> Remdesivir 200mg IV day 1, followed by Remdesivir 100mg, IV on Day 2 and Remdesivir 100mg, IV on Day 3 <input type="checkbox"/> Remdesivir 100mg IV on Day 2 and Remdesivir 100mg IV on Day 3 (day 1 already completed) <input type="checkbox"/> IV Remdesivir _____					
NOTE: Administer Remdesivir per institution/clinic policy. No refills. Remdesivir must be given over three consecutive days, unless otherwise indicated.					
Dose Adjustments (please note if there are any medications being held or adjusted below): Hold _____ for _____ days from starting Remdesivir					
Note: This prescription to only for Remdesivir and not intended for any other medications. Please fill out a separate prescription if your patient requires additional medications.					
Administration Orders					
<input type="checkbox"/> Insert saline lock and keep for 3 days for Remdesivir treatment, discontinue saline lock after treatment is complete					
Prescriber Attestation					
<input type="checkbox"/> I affirm that the patient meets the above criteria for use and appropriate assessment has been completed.					
Physician/NP Name:				Phone Number:	
Email:				CPSO#:	
Physician/NP Signature:				Date:	