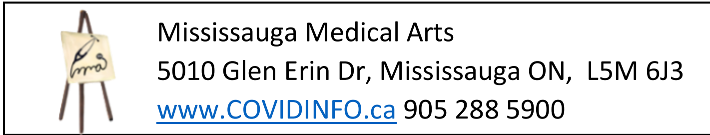
COVID-19 PAXLOVID (Nirmatrelvir/Ritonavir) Treatment Referral



Patient Information

Last Name: ______________________________ First Name_________________________ Sex: ☐M ☐ F ☐ Other

Date of Birth: ________________ Allergies: ____

Address: ____ City/Province: _____________________

Postal Code: __________________ Phone: _____________________ HCN: ___________________________

Note: Indicated for mild-to-moderate COVID-19 in adults with positive results of SARS-Cov-2 viral tests, and who are at high risk of progression to severe COVID-19, including hospitalization or death.

In order to qualify for therapy, patients need to be a) within 5 days of symptom onset and b) meet one criteria listed below.

Criteria for Use (All fields much be completed to be eligible for treatment)

☐ Date and time of symptom onset: ___________________________ (Treatment must be given within 5 days of symptom onset therefore referral must be made within 4 days)

☐ Symptoms: ____

☐ Date of positive COVID-19 test if done: ____

Creatinine (if available): _______________ eGFR: _____________ (Date: _____________)

AND at least one criteria under 1) or 2) below:

☐ 1) Immunocompromised individuals (>18 yo) regardless of vaccination status, defined as one of the following:

- ☐ Hematologic Malignancy or Bone Marrow Transplant (Please specify: _________________________________)
- ☐ Solid Organ Transplant (Please specify: ____)
- ☐ Significant immunosuppression (Please indicate type: high-dose corticosteroids > 2 weeks, alkylating agents, antimetabolites, cancer chemotherapy, TNF inhibitors, anti-CD20 agents and other immunosuppressive biologic agents)
- ☐ Primary immunodeficiency (Please specify: ____)
- ☐ Advanced or untreated HIV

☐ 2) Unvaccinated individuals (people with less than two COVID vaccine doses) at the highest risk of severe disease, defined as one of the following:

- ☐ Age >= 60
- ☐ Age >= 50 AND at least one of the following:
  - ☐ Indigenous (First Nations, Inuit, or Métis)
  - ☐ Obesity (BMI >= 30)
  - ☐ Diabetes Mellitus
  - ☐ Immunosuppressed as above (Please Specify: _______________________________________)
  - ☐ Sickle Cell Disease
  - ☐ Intellectual disability
  - ☐ Cerebral Palsy
- ☐ Other severe risk factor (Please Specify: ____)

Not authorized: Ensure that the patient does not meet any of the following criteria

- Experiencing severe COVID-19 symptoms requiring hospitalization
- Under 18 years of age, pregnant or breastfeeding
- On supplemental O2 for COVID

Referring Clinician Attestation (Must be checked to be eligible for treatment)

☐ I affirm that the patient meets above criteria for treatment with PAXLOVID (Nirmatrelvir/Ritonavir)

Please attach the patient's medication list and/or pharmacy information if available: ___________________________

MD/NP Name (print): _________________________ Direct Contact number (not office line): _______________________

MD/NP Signature: ____________________________ Date/Time: ___________ / ________ CPSO: _________________

FAX to: 289-726-2525 Updated Feb 18, 2022