NIRMATRELVIR / RITONAVIR (PAXLOVID) SCREENING AND PRESCRIBING FORM

Patient Information

Patient Name	Date of Birth	MCP

Phone Number	Address

A. Core Requirements

Indicate whether the patient **meets** the following criteria:

1. Currently an outpatient (includes patients in hospital who are under Alternate Level of Care) ☐ Yes ☐ No
2. Covid-19 symptoms started within the last 5 days. (DD/MM/YYYY): _____ ☐ Yes ☐ No
3. Had a positive Covid test (PCR or rapid antigen) on (DD/MM/YYYY): _____ ☐ Yes ☐ No

⇩

No to any of the above questions, patient does not meet criteria.

Yes to all the above questions, PROCEED to Section B.

B. Contraindications

Indicate whether the patient:

1. Has a **severe hypersensitivity** to Nirmatrelvir or Ritonavir or excipients. ☐ Yes ☐ No
2. Has **severe hepatic impairment** (Child-Pugh Class C). ☐ Yes ☐ No
3. Has **severe renal impairment (GFR less than 30mL/min)**. ☐ Yes ☐ No
   - GFR and date collected (DD/MM/YYYY): _____
4. Is taking **medications that are contraindicated** for use with Nirmatrelvir/Ritonavir. ☐ Yes ☐ No
   - If yes, please list medication(s): _____

- The following is a list of medications **contraindicated** for use with Nirmatrelvir/Ritonavir. It is a CYP3A inhibitor and substrate; therefore, may increase concentrations of other medications metabolized by CYP3A or may have a reduced concentration from strong CYP3A inducers:
  Alfuzosin, ranolazine, amiodarone, bepridila, dronedarone, flecainide, propafenone, quinidine, fusidic acid, apalutamide, venetoclax, neratinib, rivaroxaban, carbamazepine, phenobarbital, phenytoin, voriconazole, colchicine, astemizole, terfenadine, rifampin, lurasidone, pimozide, dihydroergotamine, ergonovine, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, lomitapide, salmeterol, sildenafil (only when used for the treatment of pulmonary arterial hypertension (PAH)), vardenafil (when used for the treatment of erectile dysfunction or PAH), orally administered midazolam, triazolam.

Scan the QR code for Nirmatrelvir/Ritonavir product monograph

⇩

YES to any of the above questions, the use of Nirmatrelvir/Ritonavir is contraindicated.

NO to all the above questions, PROCEED to Section C.

C. Priority Eligibility Criteria

Indicate if the patient **belongs to one of the following high-risk groups**:

☐ Moderately to severely immunocompromised individuals (see below*), 18 years of age and older, not expected to mount an adequate immune response to SARS-CoV-2 infection, regardless of vaccination status.
Please specify condition:_____

☐ Individuals 60 years of age and older, regardless of vaccination status

*Moderate to severely immunocompromised groups include:

- Active cancer treatment
- Solid organ transplant taking immunosuppressive therapy
- Moderate to severe primary immunodeficiency (ex. DiGeorge syndrome, Wiskott-Aldrich syndrome, common variable immunodeficiency, Goods syndrome, Hyper IgE syndrome)
- CAR-T cell therapy or stem cell transplant within the past 2 years
- Advanced or untreated HIV (does not include patients with undetectable viral load)
- Immunosuppressive therapy (Includes patients on high dose corticosteroids taking an equivalent of 20 mg daily prednisone or higher for greater than 2 weeks, severely immunosuppressive cancer chemotherapy, transplant related immunosuppressive drugs and biologic therapies)

If the patient <u>does not</u> belong to one of the above high risk groups, <u>treatment will not be offered.</u>

If the patient belongs to one of the above high risk groups, <u>PROCEED to Section D.</u>

D. Prescribing Details

Patient name: _____ MCP: _____

Select Nirmatrelvir/Ritonavir **dose based on patient's GFR** (provided in Section B):

<u>GFR greater than 60 mL/min</u>:	**<u>GFR between 30 and 60 mL/min:</u>**
☐ Nirmatrelvir 300mg/ Ritonavir 100mg p.o. Q12H x 5 days	☐ Nirmatrelvir 150mg/ Ritonavir 100mg p.o. Q12H x 5 days

Prescriber Name: _____ Phone number: _____ License Number: _____

Prescriber Signature: _____ Date (DD/MM/YYYY):_____

<u>Please Note</u>: Paxlovid is dispensed through community based pharmacies. Screening and Prescribing Forms completed by physicians or nurse practitioners should be faxed to the pharmacy of the individual's choice for dispensing, once it has been confirmed that the pharmacy has Paxlovid in stock. Pharmacists in Newfoundland and Labrador, may choose to prescribe Paxlovid as part of their scope of practice, provided the requirements of the Newfoundland and Labrador Pharmacy Board are met.