Changing the Way We Work

All about Paxlovid – April 22, 2022

Panelists: Dr. Andrew Morris, Dr. Sohal Goyal, Dr. Kelly Grindrod
Co-hosts: Dr. Liz Muggah, Dr. David Kaplan | Moderator: Dr. Tara Kiran

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Curated answers from CoP panelists and co-hosts to in-session questions posed by participants, based on current guidance and information available at the time.

ELIGIBILITY | ASSESSMENT

- **Why do the provincial criteria for Paxlovid in the over 70 group differ?**

I think [panelist] Dr. Andrew Morris said it well: the MOH guidance is who should be considered for testing (wider net) and the SAT is about the evidence for who would benefit

- **How do we balance the Science Advisory Table recommendations vs the Ontario Public Health recommendations for patients over the age of 70 and low risk otherwise? Patients want the drug as they think it cures them.**

It's very difficult, but when we talk to each patient, many choose not to take the medication if at low risk. [See also previous question/answer.]

- **54-year-old, triple vaxxed, morbidly obese, type 1 DM, HTN – positive PCR – requesting Paxlovid. She had good knowledge of the tx. No drug interactions. She does not meet the criteria. Could you comment if it would be appropriate to give?**

We are following the OST guidelines and she would not qualify. She is not eligible. So, we do not Rx.

- **How symptomatic does someone need to be to consider prescribing Paxlovid**?

Mild to moderate symptoms (ie need to have symptoms).

- **Are we assuming any sick person with fever, runny nose has COVID? They are testing negative rapid (several times) as well as negative at an assessment centre (pcr).**

No, if negative with repeated RAT and PCR this could be an infection with one of the other respiratory viral illnesses that are around (more so now because masking has been reduced).

- **Please comment on the use of Paxlovid in immunocompromised adolescents (RA or IBD on biologic agents) whether 3-4 doses or 0, 2 doses.**

We are not using it for those under age 18, even though the U.S. is using over age 12.

- **Can Paxlovid be given to a patient who has symptoms but has not done any COVID test? Or rapid test is negative?**

No, you need a positive test to get Paxlovid. [https://covid-19.ontario.ca/covid-19-antiviral-treatment#how-to-get-treatment]

- **What kind of proof of a positive test is required for a patient to qualify for Paxlovid? If a patient had a positive RAT at home and they tell you this is this sufficient proof?**

Yes, self-administered + RAT is sufficient - just be sure they have read the test correctly and yes, need to treat within 5 days. If you can have them send a photo/look at it by video, even better.

- **Is patient report of positive home rapid test adequate to confirm they have COVID?**

Yes, just make sure they have read it correctly; if you can get a photo/video evidence of test even better.

- **I work as a GP-Hospitalist in hospital and we admit patients with COVID and see patients who acquire COVID while in hospital. Should we be starting Paxlovid for these higher risk patients or is there no benefit once they are already hospitalized?**

The benefit is preventing progression to severe disease. Setting does not matter—we have worded it in the Science Table document to be clear about that. Hospitalized patients are eligible.

- **Are there still only 15 centres for COVID assessment AND treatment?**

No, there are many more now and the number keeps increasing as more assessment centres get comfortable with prescribing.

[List of assessment centres dispensing Paxlovid:
https://www.ontariohealth.ca/sites/ontariohealth/files/2022-02/PaxlovidSites.pdf]

- **Can I refer to the NYGH COVID cold and flu clinic to get Paxlovid instead of me prescribing it? Can any patient go there, or do they have to meet certain criteria (e.g. age, did not get vaccine or etc.)?**

Yes, you can refer; yes, they need to have them meet the MOH criteria for consideration of treatment (Paxlovid or other). Obviously, screening out those who are sick enough that they need to go to ED.

- **How long are your assessments taking?**

With a good referral, 30 minutes at least.

- **Is it reasonable when a COVID-positive patient calls the office for our admin staff to go through the Ontario COVID treatment screener with them to help us prioritize calling those who flag as higher risk and need to be called same day? We are finding it hard to squeeze in every patient who calls because they are COVID positive the same day. Any practical tips appreciated!**

Good script here in the OH Treatment pathway:
https://www.ontariohealth.ca/sites/ontariohealth/files/2022-04/Guidance%20for%20health%20care%20providers%20-%20Access%20to%20Paxlovid%20-%20EN.pdf

[Additional resources:
- Online form to help determine eligibility, designed by panelist Dr. Sohal Goyal:
https://docs.google.com/forms/d/e/1FAIpQLScwSoOlHJHWb8XIgigpVvBvReC-UPhvHK89dhEKROJnmIMFvQ/viewform
- Ontario Health pathways for Paxlovid access:
https://www.ontariohealth.ca/sites/ontariohealth/files/2022-04/Guidance%20for%20health%20care%20providers%20-%20Access%20to%20Paxlovid%20-%20EN.pdf
- Ontario Health memo with Paxlovid resources: https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources/clinical-care-office-readiness/oh-paxlovid-tools-april-2022.pdf]

SPECIAL POPULATIONS

- **We really need some direction for LTC. Most are >70, with mutl rf but also multiple drug interaction risks. They are also largely well vaccinated.**

Agree. This is a challenging group. Also, given that you cannot split or crush the tabs, it can be a challenge for them to take Paxlovid or get to an infusion clinic for remdesivir IV x 3 days. The best strategy in this group is to prioritize vaccination, which may limit any potential benefit of treatment.

[**UPDATE**: Therapeutic Management of Residents of Long-term Care with COVID-19, Science Advisory Table, April 22, 2022: https://covid19-sciencetable.ca/wp-content/uploads/2022/04/Therapeutic-Management-of-Residents-of-Long-term-Care-Homes-with-COVID-19_published_20220422.pdf

- **Is there any evidence or recommendations for LTC population specifically, considering they are very elderly/frail, and at risk of drug side effects/ interactions?**

There will be LTC recommendations being posted by the Science Table later today. Stay tuned!

[**UPDATE**: Therapeutic Management of Residents of Long-term Care with COVID-19, Science Advisory Table, April 22, 2022: https://covid19-sciencetable.ca/wp-content/uploads/2022/04/Therapeutic-Management-of-Residents-of-Long-term-Care-Homes-with-COVID-19_published_20220422.pdf]

- **Important to check elderly's prescriptions of COCV. The ODB medication list is there, including medications you didn't prescribe yourself.** https://portal.connectinggta.ca/ProviderPortal/index.do#

Yes. COCV [ConnectingOntario ClinicalViewer] has been great.

- **Please comment on oncology patients receiving chemo and eligibility for Paxlovid, and will family doctors be expected to navigate this in terms of drug interactions? Or is there work being done with the cancer teams about their involvement in prescribing?**

There is work being done with specialists as well and they can prescribe Paxlovid. I've already had that happen with a transplant patient who had his specialist give the Rx – agree all avenues to Rx need to open.

- **I look after a large group of patients with developmental disabilities. They are often on drugs that interact, and I am really at a loss about whether or not to prescribe to this group. Are you aware of any studies in this group?**

The main barrier may be that they are on certain seizure drugs that are enzyme inducers (carbamazepine, phenytoin), and Paxlovid would be contraindicated—mostly as it's not likely to work. This would also be the case if there are on certain longer acting anti-psychotics. For these patients, remdesivir could be an option but it's not an ideal one either.

- **Any data available on patients with chronic lung disease younger than 60, any benefit with Paxlovid?**

It depends on vaccination status.

[More research on Paxlovid underway in the PANORAMIC study: https://www.panoramictrial.org/for-healthcare-professionals]

- **Can you comment on the use of Paxlovid in pregnancy even with vaccines?**

We have no data! It makes it really challenging. Ritonavir mostly safe in pregnancy. But pregnant and vaccinated doesn't appear to be substantially high risk. The challenge is pregnant + unvaccinated.

PRESCRIBING | DRUG INTERACTIONS

- **Where can patient have Paxlovid prescription filled?**

I believe it is about half of pharmacies at this point that have signed up to dispense. You can get the updated list here on the MOH site about which pharmacies have it. You may wish to call the patient's pharmacy to go over drug interactions with their pharmacist but then dispensed from another one if they don't have it there.

[UPDATE] Pharmacy locations dispensing Paxlovid

  - downloadable Excel list, link on Ontario's COVID-19 website: https://covid-19.ontario.ca/covid-19-antiviral-treatment

  - Interactive Google map: https://www.google.com/maps/d/viewer?mid=1PdhbqFxXXfkgV4upoX64E1Fu6xLtJhDt&ll=46.214375048778656%2C-84.5458116&z=6

- **How to access a pharmacist with expertise and time in a timely fashion, given how busy community pharmacists are.**

I know. We have raised this need to MOH that we need to support access to FPs to specialist pharmacists for the most complex cases. Some hospitals have pharmacists accessible to the community docs; you can also try calling the CAC to talk with their docs/team.

- **Do pharmacists have access to OLIS [Ontario Laboratories Information System]?**

Many but not all do. [Accessible through ClinicalConnect, ConnectingOntario ClinicalViewer: https://ehealthontario.on.ca/en/health-care-professionals/connectingontario]

- **If patient does not qualify for Paxlovid due to contraindicated co-administered drugs which cannot be stopped or absolutely contraindicated, how effective is remdesivir compared to Paxlovid?**

I consider remdesivir comparable to Paxlovid in efficacy. [This response reflects the view of the panelist who responded to the question.]

- **Can you discuss the relative benefit for patients with multiple comorbidities who are on multiple drugs that interact with Paxlovid? Is it worth stopping these other meds to take Paxlovid? Any tools/calculators to help with this?**

Seems like IV remdesivir is a good alternative.

- **Any tips re EMR integrated tools to support safe prescribing of nirmatrelvir/ritonavir?** e.g. https://ehealthce.ca/userContent/documents/COVID-19/Paxlovid%20Prescription%20Form%20-%2004122202-%20DC.pdf

Check out the amazing work by eHealth Centre for Excellence with a Paxlovid prescribing tool for your EMR (Telus, Oscar, Accuro): https://ehealthce.ca/COVID-vax.htm#Paxlovid%20Resources)

[**UPDATE**: eHealth CE –Paxlovid eligibility EMR search available as of April 28: https://ehealthce.ca/COVID-Therapeutics.htm]

- **Please comment on options when medication interactions preclude use of Paxlovid.**

The Ontario Science Advisory Table has great info on this – for mild/moderate, options include budesonide, fluvoxamine, remdesivir, you could chat this through with the patient or send to CAC if you aren't sure.

[Ontario COVID-19 Science Advisory Table – **Paxlovid: What Prescribers and Pharmacists Need to Know**: https://covid19-sciencetable.ca/wp-content/uploads/2022/02/NirmatrelvirRitonavir-Paxlovid-What-Prescribers-and-Pharmacists-Need-to-Know-with-Appendix_20220223.pdf]

- **When I prescribed Paxlovid the other day the patient needed a reduced dose because of renal issues and it wasn't a problem because the pharmacy had the 150 mg dose but not the 300 mg dose…what would we do in a situation like this if the patient actually needed 300 mg since it wasn't stocked? Because of the combined meds I couldn't really double up a 150 mg dose for a patient.**

The blister pack contains 2 x 150mg nirmatrelvir for each dosing time (ie there is no 300mg tablet). For renal dosing, the pharmacy can just remove the extra 150mg tablet for each dosing time.

- **How do you manage the risk/benefit of holding NOAC for Rx? We do not have time to consult cardiology in the 5-day period.**

This is an area of a lot of debate, even for specialists. We are working on a supplementary guidance tool to help with this. Hoping we will complete it next week. The other challenge here is patient willingness to use LMWH to bridge when needed, training patients who are meant to be isolating at home, and having quick/reliable access to LMWH in more rural communities.

[UPDATE – new tool: Paxlovid for a patient on a DOAC: https://covid19-sciencetable.ca/wp-content/uploads/2022/05/Paxlovid-for-a-Patient-on-a-DOAC_published_20220511.pdf]

- **If patients only have mild symptoms by day 4, but eligible for Paxlovid – what is best?**

If they are improving, we have an honest discussion. Many choose not to take the medication.

- **Do we need to ensure follow up calls on day 3 and 5? Or direct patient to call back if worsening?**

Good question - I think up to you how to manage based on your clinical judgement on that patient and their level of illness. Follow is generally a good idea but no specific guidance on when to do this.

- **For pts without home bp cuff, if reducing dose, and given COVID positive and isolation, how to monitor and how often? Is there a need to add other meds?**

The pharmacy may be able to send a blood pressure meter with their drug delivery if the patient is willing to buy one (or perhaps has some insurance coverage for it). They can monitor 12-24 after the first dose and I'd monitor daily. Given the interaction, a lower amlodipine dose should give the same serum levels as the regular dose when the patient is not taking ritonavir. For monitoring, we need to watch to see if the interaction is leading to excess serum concentrations and hypotension.

OTHER TREATMENTS | THERAPEUTICS

- **Fluvoxamine is also recommended as treatment options but lots of drug interactions with this as well. Will we be getting guidance regarding this option in more detail?**

Not today – great summary on prescribing these on the Ontario Science Table website.

[Fluvoxamine: What Prescribers and Pharmacists Need to Know: https://covid19-sciencetable.ca/sciencebrief/fluvoxamine-what-prescribers-and-pharmacists-need-to-know/ (Ontario Science Advisory Table)]

- **Can you give update on other therapeutics if patient presents after five days (Remdesivir, Luvox)**

Patients likely will get marginal benefit from remdesivir (if at high risk for hospitalization). Fluvoxamine and inhaled corticosteroids both appear to have some benefit—although the certainty of the benefit is somewhat low at present.

- **Can you comment on the evidence and role of newly approved Evusheld?**

The paper was published in NEJM this week. Very small numbers of patients on placebo developed symptomatic infection, and Evusheld seemed to reduce it. Large trial, but marginal benefits. There were <4% immunocompromised patients in the trial—the ones for whom Evusheld is approved—with too few numbers in each arm to give us any insight into the benefit.

[NEJM article: https://www.nejm.org/doi/full/10.1056/NEJMoa2116620]

- **Future session – can we address Evusheld now that it's authorized, for prevention.**

Yes! If we have time we will cover today!

[Recording of May 13 CoP session which includes an Evusheld segment and resources: https://www.dfcm.utoronto.ca/past-covid-19-community-practice-sessions]

EMERGING EVIDENCE – PAXLOVID

- **In EPIC-HR what variant did most patients have?**

Delta

- **As the NEJM only included patients who had Sx for </= 3days, do we have guidance to support use in those after the 3-day mark?**

The study was for Sx for <=5 days.

- **Are there any trials planned in higher risk vaccinated patients?**

My understanding is that there is ongoing subset trial.

- **The people we will be prescribing Paxlovid to are also very likely already vaccinated – I have not found information about benefit in these people. Comment?**

As mentioned in my part of the talk, we just don't know benefits of Paxlovid in vaccinated.

- **Some on Twitter are describing a "rebound" of symptoms after a Paxlovid 5-day course is finished – negative on RAT then positive again. Can you please comment on this?**

Have heard this too. We know so little about this drug. Does it alter the natural history? Is 5d treatment long enough?

- **There are many concerns about the ONE study we have information about on Paxlovid (conflicts, ITT issues etc). Should we be concerned?**

I am ALWAYS concerned with single studies. But we have a treatment and we are still in a pandemic. I think the drug likely works. But the indication creep is problematic. (To be honest, I have zero confidence that it does much in fully vaccinated individuals.)

- **What are the thoughts about driving viral resistance with overuse of this drug?**

I worry about it—but we don't know.

- **What are risks of resistance to Paxlovid?**

Unknown, we have not seen resistance.

- **This hasn't yet happened as I've only given two Paxlovid prescriptions, but do we know what happens if someone stops due to side effects? One of the high risk people I started on it 2 days ago had so few symptoms but likely would end up in hospital if worsened, and I almost felt guilty starting the meds in case of side effects. I worry if she feels sick on meds she will stop.**

This would be similar to stopping an antibiotic early. Preparing them for side effects can help quite a bit (so the day 2-3 telephone follow-up). If they do stop early, make sure any adjusted or held meds are restarted 2 days after their last Paxlovid dose.

- **What are the issues with stopping Paxlovid abruptly and prior to day 5? (apologies if this has already been asked, there are 93 questions in here)**

Unknown. Probably low risk for most patients—but might be real for those who are highest risk.

- **Does Paxlovid reduce infectiousness and long COVID risk?**

Unknown.

PAXLOVID: OTHER TOPICS

- **If they are getting better, does that mean there is no risk of delayed "hyper-inflammation"?**

No—but the risk seems relatively low.

- **Is there a mechanism to bill leisure travelers for Paxlovid (assuming they qualify?)**

Interesting. I do not think so, if you qualify then the drug is covered.

- **What is the cost, is it covered by ODB?**

Yes, covered by ODB. [When assessed and recommended for treatment, there is no cost to any Ontario patient and a Health Card is not required.]

- **Is any organization working on a "why you don't need nirmatrelvir/ritonavir" patient handout? Thinking of this from a stewardship perspective.**

Great idea. I have not seen it!

TESTING | ISOLATION

- **What does "preliminary positive" mean on a RAT from Shoppers Drug Mart?**

Interesting … have not seen this, fully agree it should be +ve or -ve. I would call them to ask what their process is for confirming positivity.

- **Given the low sensitivity of RATs, is there any value of RATs other than for surveillance?**

1. If positive in a symptomatic patient, it is almost certainly a true positive. They can isolate, and also use this re: eligibility for Rx.
2. When swabbing cheeks, back of throat/tonsillar pillars, and then nares, it appears to be much more sensitive than advertised. We don't know exactly how good, but my experience is it is quite high (70%).

- **Is a weak positive RAT a real positive? Are positive tests that appear after 15 minutes a true positive?**

Yes, a weak +ve is a +ve. Tests after 15 minutes may not be accurate. That being said, if you are +ve at 18 minutes, you may wish to repeat the test 24 hours later. Dr Morris may be able to explain the science behind the tests and what happens chemically post 15 min to make it less accurate.

- **Can you please clarify isolation after a positive test? Does a negative test imply being less contagious? In other words, do people have to test negative before ending isolation?**

According to PH guidance, after a positive test a fully vaxed person should isolate for 5 days (and symptom free for 24 hours). However, if people have extra rapid tests a positive test on day 5 or 6 means that they are likely still contagious and should ideally remain in isolation. 10 days of isolation if not vaccinated (for the whole household too).

OTHER

- **Is obesity still one of the most important risk factors for hospitalization?**

It has remained a strong signal.

- **Immunocompromised patients who already had 4 doses, are they eligible for 5th/booster?**

Yes, this has been a bit unclear in the guidance to date, but we understand from MOH this will be addressed shortly in their documents/communication. A 5th dose/second booster is available to those who are immunocompromised and over age 60, based on three doses being their "primary series".

[More information: "Do I need a booster? When should I get it?" in the Confused About COVID? patient information series, from UofT DFCM and OCFP: https://rebrand.ly/3rd-dose]

- **Now we have era of requests for "medical letter for travel ". I am not very comfortable with this. Test report has to be all [that] people need. How soon after positive test should person be eligible to travel? How long do they remain immune? Can they sit in the crowd without mask? I am looking for advice and other people's opinions.**

Our role as family docs is to provide the facts like this person told me they tested +ve with home rapid test on x day. You don't need to make any declarations/decisions on if/when they can travel, that is for the travel company/country. Good info on this in a past OCFP President's Message and CPSO has nice guidance on this too. Remember you can also charge for these letters.

[OCFP President's Message, Feb. 4, 2022: https://www.ontariofamilyphysicians.ca/news-features/family-medicine-news/~240-Guidance-for-COVID-19-therapeutics-travel-notes-and-more]

I have temptation to charge so much, that going for $40 test to Shoppers before trip will be less expensive :-). This is so complex … Can I refuse issuing such letters? I will likely call CMPA for support. I often feel that some of patients are intentionally getting in contact with COVID, to obtain such letter.

You can direct them to a travel clinic if you choose to write these letters.

- **There seems to be so much symptomatic illness from COVID despite triple vaccination. Any comments?**

There is a lot of breakthrough infection! We think—from a guidelines and patient management perspective—that "severe" means: progression to the inflammatory phase of disease (i.e. requiring hospitalization for oxygen).

However, from the patient perspective, they can feel pretty crappy without progressing to the inflammatory phase of disease. Some will get hospitalized for worsening chronic illness, but most will not need oxygen. Paxlovid helps only with the progression.

- **If "clinical trials don't establish safety", how do we address concerns with patients about long-term effects of COVID vaccines?**

We now have multiple clinical trials and surveillance for vaccines, that have been used globally since December 2020 with billions of doses administered. Additionally, we have ZERO evidence of long-term untoward complications of vaccines.

Paxlovid has been studied in a few thousand patients so far, and has been on the market for about a month globally. Huge difference. Post-marketing surveillance is how we primarily establish safety with drugs and vaccines.

- **Can you comment on whether our community clinics should be continuing with mask mandates once the province lifts the health care facility mandates on April 27 (if that actually happens)?**

We understand from CMOH announcements that the mask mandate will stay in place in health care settings, which we support.

[Ontario's announcement for masking requirements to continue to June 11, 2022 in some indoor settings: https://news.ontario.ca/en/release/1002098/masking-requirements-continue-in-select-indoor-settings]

- **What is the main way of spread of BA2 now? Schools, workplace, social get-togethers (restaurants)?**

Impossible to know setting, but it would predictably remain indoor transmission, poor ventilation, unmasked.

- **Any updates on newest variants?**

There are a host of sub-variants emerging around the world and in Canada. The nomenclature is complicated, but there is one emerging in Canada and UK, BA.12.x.x, that may be as much as 2.5x more transmissible over BA.2 but not more severe based on preliminary info. (Yup, hard to imagine!) There are other variants of concern, including the XE variant—the transmissibility of BA.2 and the severity of Delta—but it is unclear if this will emerge to become dominant. Bottom line: stay tuned.

- **How can we access long COVID-19 clinics in GTA?**

Good guidance on navigating access via this OH guide for primary care for post COVID https://www.ontariohealth.ca/sites/ontariohealth/files/2021-12/PostCOVIDConditionsClinicalGuidance_EN.pdf

[See also: list of COVID-19 outpatient rehabilitative programs, compiled by Rehabilitative Care Alliance: https://www.rehabcareontario.ca/47/COVID-19_Outpatient_Rehabilitation_Programs/?utm_source=sfmc&utm_medium=email&utm_campaign=OMA+News+February+11+2022&utm_term=https%3a%2f%2fwww.rehabcareontario.ca%2f47%2fCOVID-19_Outpatient_Rehabilitation_Programs%2f&utm_id=204675&sfmc_id=7568925]

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These additional questions were answered live during the session. To view responses, please refer to the session recording.

- I have had a few patients ask for a Rx for Paxlovid to have on hand in case they get COVID. Could you please comment on this?
- The Science table recommendations about who should take Paxlovid seem to differ (more conservative) than what comes out from the government and local PHU. Why is this the case?

- When a patient on a DOAC qualifies for Paxlovid, is it safe to switch them onto dabigatran, assuming they have normal renal function? If eGFR<30, then what are their options? If using LMWH to bridge, should 1st dose be given in ER?
- Can you please clarify isolation after a positive test? Does a negative test imply being less contagious? In other words, do people have to test negative before ending isolation?
- Is there any evidence that Paxlovid is helpful in fully vaccinated patients (ie 3-4 COVID vaccines)- my elderly are starting to call and are COVID +ve but mildly sick and asking "is it worth it"?
- Can you speak to on-demand Rxs for nirmatrelvir/ritonavir in "high-risk"- specifically should all patients on biological drugs for RA actually get an Rx for this "just in case" Vs transplant patients etc?
- What is the NNT for a patient who meets criteria for Paxlovid based on the MOH eligibility criteria vs. Ontario science table criteria? And what's the NNH for patients treated outside the science table criteria?
- Immunocompromised qualify for Paxlovid. What is the actual risk for patients on MTX, SSZ, biologics, etc.? Is there data for fully vaccinated younger patients on these meds? If not, do we know how likely they are to develop severe disease?

Additional unanswered questions:

- How often can Paxlovid be given? How much time needs to pass to be able to prescribe it to the same patient twice if they get reinfected?
- Please share updates on development of updated mRNA vaccines.
- Can you provide details on roll-out plan for medicago I.e. how, where and when will be available to eligible patients?
  how does it compare to mrna vaccines in preventing against severe illness from variants (if data is available)?
- Can you comment on how OHTs or smaller groups are developing processes for their area/region/sub-region? Particularly for those who need a creatinine to inform the prescription?
- Are there any updates regarding the Omicron-specific vaccine that may be coming out later this year? People are asking whether they should get 4th dose or wait for the Omicron-specific vaccine.
- If someone is triple vaccinated and also had recent COVID infection (in 2022) how likely are they to again be infected with COVID 19?
- Considering a process where CAC docs (all FPs) refer all potential Paxlovid patients to FHT Pharmacist for EMR review - any thoughts?
- I saw male 86y yesterday, eligible eGFR 62 but creatinine clearance 40 ml/min. Is lower dose not better though eGFR >60?

- If there is a cardiac arrhythmia only (I am thinking of SVT with normal LV function + neg ischemia workup), does that count as a cardiac risk factor?
- What are people doing for LTC patients with COVID who are vaxed x 4?
- If judging by whether improving, what about the risk of deterioration day 7-12 etc, and the guideline to tx when mild?
- High risk patient presenting with mild disease or improving symptoms, any data on risk of progression to more severe disease and any advise on treatment consideration?
- So what guidelines should we be considering now? How to stratify for elderly where we have less evidence? What if it is a patient over 80 with only hypertension (1 medication), GFR WNL, lives at home alone? Symptoms not better day 3. Benefit of Paxlovid?
- I've had two eligible (SAT) patients , pcr positive , who had relatively mild illness who chose to see" how they feel / do" up to day 5 . Comments?
- 80 year old with metastatic cancer, still very independent of all ADL, still within 5 days of onset(currently not on chemo and has adrenal insufficiency and on hydrocortisone, has symptoms, +ve RAT twice , normal egfr and wants treatment. Had 3x doses vaccine. Any thoughts?
- Are you suggesting then we get eGFR done if none available in last 6 months? We would be sending COVID + pt to community lab then to get done?
- Do we have any slide on immunization especially for HCW. Update on 4th booster shot for docs?
- In the study, I think they studies a subgroup of patients with symptoms for 3 days or less. Was it this subgroup or those with 5 days or less of symptoms that had the 89% reduction in hospitalization?