



Anecdotally, I have seen an increase in nursing home COVID cases over the last 2 weeks. Modeling indicates that this is expected and likely to get worse this summer.

As we see more cases of COVID-19 in our nursing homes, I wanted to pass along some information regarding the use of Paxlovid.

We should be considering Paxlovid for anyone in our nursing homes who has mild-moderate disease. I would consider a cough or fever symptoms of mild disease. The ultimate treatment decision will be between the physician and the patient/family, obviously. The decision to use Paxlovid should be made within 48-72 hrs of a positive COVID test. Not all nursing home patients will be a good candidate for Paxlovid due to drug interactions and other patient specific factors.

We may need to reach out to our pharmacists to monitor the availability of Paxlovid and ask them to help with renal dosing and assessing drug interactions. Our pharmacists can be very helpful in determining the risk/benefit ratio for use of Paxlovid in our residents. It may not always be an easy decision.

[Ritonavir-Boosted Nirmatrelvir \(Paxlovid\) | COVID-19 Treatment Guidelines \(nih.gov\)](#)

Paxlovid (nirmatrelvir/ritonavir) 300/100 mg PO BID x 5 days.

GFR >60: no dosage adjustment

GFR 30-60: Nirmatrelvir 150mg/ritonavir 300mg bid x 5 days

GFR <30: do not use it.

There are a number of very important drug interactions with Paxlovid including eliquis (apixaban), xarelto (rivaroxaban) and many other medications. I have included some links below to help with the treatment decision. The Liverpool drug interaction checker is a useful tool as well.

[Paxlovid Drug-Drug Interactions | COVID-19 Treatment Guidelines \(nih.gov\)](#)

[Liverpool COVID-19 Interactions \(covid19-druginteractions.org\)](#)

Additional Information:

[Nonhospitalized Adults: Therapeutic Management | COVID-19 Treatment Guidelines \(nih.gov\)](#)



Figure 1. Therapeutic Management of Nonhospitalized Adults With COVID-19

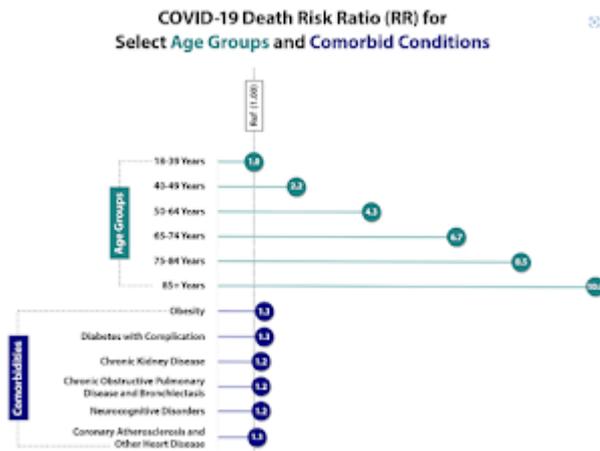
PATIENT DISPOSITION	PANEL'S RECOMMENDATIONS
Does Not Require Hospitalization or Supplemental Oxygen	<p>All patients should be offered symptomatic management (AIII).</p> <p>For patients who are at high risk of progressing to severe COVID-19,* use 1 of the following treatment options:</p> <p>Preferred Therapies Listed in order of preference:</p> <ul style="list-style-type: none"> • Ilxasavir-based nirmatrelvir (Paxlovid)[†] (AIIa) • Remdesivir[†] (BIIa) <p>Alternative Therapies For use (ONLY when neither of the preferred therapies are available, feasible to use, or clinically appropriate. Listed in alphabetical order:</p> <ul style="list-style-type: none"> • Bebtelovimab[†] (CII) • Molnupiravir[†] (CIIa) <p>The Panel recommends against the use of dexamethasone[†] or other systemic corticosteroids in the absence of another indication (AIII).</p>
Discharged From Hospital Inpatient Setting in Stable Condition and Does Not Require Supplemental Oxygen	The Panel recommends against continuing the use of remdesivir (AIIa), dexamethasone (AIIa), or baricitinib (AIIa) after hospital discharge.
Discharged From Hospital Inpatient Setting and Requires Supplemental Oxygen For those who are stable enough for discharge but who still require oxygen [†]	There is insufficient evidence to recommend either for or against the continued use of remdesivir or dexamethasone.
Discharged From ED Despite Near or Increasing Need for Supplemental Oxygen When hospital resources are limited, inpatient admission is not possible, and close follow-up is ensured [†]	<p>The Panel recommends using dexamethasone 6 mg PO once daily for the duration of supplemental oxygen (dexamethasone use should not exceed 10 days) with careful monitoring for AEs (BIII).</p> <p>Since remdesivir is recommended for patients with similar oxygen needs who are hospitalized, clinicians may consider using it in this setting. As remdesivir requires IV infusions for up to 5 consecutive days, there may be logistical constraints to administering remdesivir in the outpatient setting.</p>

Rating of Recommendations: A = Strong, B = Moderate, C = Weak
Rating of Evidence: I = One or more randomized trials without major limitations, II = Other randomized trials or subgroup analyses of randomized trials, III = Nonrandomized trials or observational cohort studies, IV = Expert opinion

[Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals | CDC](#)

Risk of death increases with age. Risk 6.7+ for those over 65 y/o.

Comorbid conditions increased risk of death from COVID-19 as well.



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