



# PAXLOVID Treatment for COVID-19 Referral Form

PH: 937-641-5500 Fax to: 937-641-4451

One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

Fax completed form and patient medication list to Dayton Children's Outpatient Pharmacy 937-641-4451.  
E-scribe the prescription to Dayton Children's Hospital Outpatient Pharmacy, 1 Children's Plz, Dayton, OH 45404.  
If unable to e-scribe call outpatient pharmacy at 937-641-5500.

**PLEASE PRINT (All Information is Required)**

**Referral Date:** \_\_\_/\_\_\_/\_\_\_

**Date of Symptom Onset:** \_\_\_/\_\_\_/\_\_\_

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Patient's Name: _____	Referring Provider: _____
<input type="checkbox"/> Male <input type="checkbox"/> Female                      DOB: _____	Provider Fax: _____
Parent/Guardian Name(s): _____	Provider Phone: _____
Height: _____                      Weight: _____	<b>Use office stamp in this space:</b>
Home Phone: _____	
Cell Phone: _____              Work Phone: _____	
Email address: _____	
Preferred Contact Phone: <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home	
Do you need an interpreter? _____	Provider Address:
Patient is in custody of: <input type="checkbox"/> Parents <input type="checkbox"/> Guardians <input type="checkbox"/> CSB	
Address: _____	
City: _____              State _____              Zip _____	

**Patient must meet ALL of the following criteria:**

- |                              |                             |                                      |
|------------------------------|-----------------------------|--------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mild-to-moderate COVID-19 infection  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Onset of symptoms within past 5 days |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Age $\geq$ 12 years                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight $\geq$ 40 kg                  |

**Please indicate if patient meets any of the following criteria:**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Moderate renal impairment (eGFR 30-60 ml/min) – not a contraindication to PAXLOVID, requires dose adjustment |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Severe renal impairment eGFR < 30 ml/min) – contraindication to PAXLOVID                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Severe hepatic impairment (Child-Pugh Class C) – contraindication to PAXLOVID                                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Concurrent use of any of the following medications (contraindication to PAXLOVID):                           |
- Anticonvulsant: carbamazepine, phenobarbital, primidone, phenytoin
  - Cystic fibrosis transmembrane conductance regulator potentiators: lumacaftor/ivacaftor (ORKAMBI)
  - Ergot derivatives: dihydroergotamine, ergotamine, methylergonovine
  - Sedative/hypnotics: triazolam, oral midazolam
  - Antipsychotics: lurasidone, pimozide
  - Antimycobacterials: rifampin
  - PDE5 inhibitor: sildenafil (REVATIO) when used for pulmonary arterial hypertension
  - Antiarrhythmic: amiodarone, dronedarone, flecainide, propafenone, quinidine
  - HMG-CoA reductase inhibitors: lovastatin, simvastatin
  - Alpha<sub>1</sub>-adrenoreceptor antagonist: alfuzosin
  - Antianginal: ranolazine
  - Anti-gout: colchicine
  - Benign prostatic hyperplasia agents: silodosin
  - Cardiovascular agents: eplerenone, ivabradine
  - Immunosuppressants: voclosporin
  - Microsomal triglyceride transfer protein inhibitor: lomitapide
  - Migraine medications: eletriptan, ubrogepant
  - Mineralocorticoid receptor antagonists: finerenone
  - Opioid antagonists: naloxegol
  - Serotonin receptor 1A agonist/serotonin receptor 2A antagonist: flibanserin
  - Vasopressin receptor antagonists: tolvaptan
  - Anticancer drugs: apalutamide
  - Herbal products: St. John's Wort (*hypericum perforatum*)

**DIAGNOSTIC CRITERIA**

**Patient must meet ONE of the following criteria**

- BMI  $\geq$  85th percentile for ages 12-17 years or  $\geq$  35 for those  $\geq$ 18 years on High-level immune suppression
  - Chronic Kidney Disease
  - Diabetes
  - Immunosuppressive Disease
  - Currently on immunosuppressive treatment
  - Sickle Cell Disease
  - Congenital or acquired heart disease
  - Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity
  - Medical-related technological dependence (tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))
  - Severe asthma (requiring injectable biologic therapies) or other chronic respiratory disease
  - Current smoker
  - Active cancer
- 
- Paxlovid (nirmatrelvir 300 mg/ritonavir 100 mg) by mouth twice daily for 5 days
  - Paxlovid (nirmatrelvir 150 mg / ritonavir 100 mg) by mouth twice daily for 5 days for patients with moderate renal impairment