



**PATIENT INFORMATION**

Patient Name		Personal Health Number (PHN)	Date of Birth (YYYY / MM / DD)
Address		City	Postal Code
Phone Number	Allergies		
Date of Symptom Onset (YYYY / MM / DD)			

**ELIGIBILITY CRITERIA (see also NOTE on reverse)**

- Confirmed COVID-19 **AND** symptomatic for five days or less (symptom onset day is considered day zero)  
**OR**  
 Pre-emptive prescription for future use. I authorize that the patient is aware they must meet eligibility criteria of confirmed COVID-19 and symptomatic for 5 days or less at the time of filling Paxlovid

**AND** – Are at increased risk for disease progression (tick one box):

Age	Number of Vaccine Doses		
	0 or 1 (lack of primary series)	2 (primary series WITHOUT booster)	3 (primary series PLUS booster)
Any adult	<input type="checkbox"/> identified as clinically extremely vulnerable (CEV) Group 1, Group 2 and Group 3 (See Toolkit #2 – CEV Definitions)		
18-69 OR 18-59 if Indigenous	<input type="checkbox"/> ≥ 1 serious chronic medical condition (see below for definitions) Not at increased risk otherwise	<input type="checkbox"/> ≥ 1 serious chronic medical condition (see below for definitions) Not at increased risk otherwise	Not at increased risk
70+ OR 60+ if Indigenous	<input type="checkbox"/> Any individual	<input type="checkbox"/> Any individual	<input type="checkbox"/> ≥ 1 serious chronic medical condition (see below for definitions) Not at increased risk otherwise

Nirmatrelvir/ritonavir may be considered in patients who reside in long-term care (LTC) facilities.

Serious chronic medical conditions include: stroke, heart failure or heart disease, chronic kidney or liver disease, diabetes, chronic lung disease such as COPD, bronchiectasis or interstitial lung disease, neurological disease such as Parkinson's disease.

No exclusion criteria (see over for details)

Drug-drug interactions assessed using best possible medication history (select one below):

- No serious drug-drug interactions identified  
 Interactions identified and management plan implemented (please describe below):

\_\_\_\_\_

\_\_\_\_\_

Assessment completed by pharmacist (if applicable) **Pharmacist Name:** \_\_\_\_\_

**PRESCRIPTION**

- eGFR greater than or equal to 60 mL/min nirmatrelvir/ritonavir 300/100 mg (Paxlovid) PO BID x 5 days  
 eGFR 30-59 mL/min nirmatrelvir/ritonavir 150/100 mg (Paxlovid) PO BID x 5 days (pharmacist to remove 10 tablets of nirmatrelvir for Paxlovid pack)  
 This is a pre-emptive prescription for future use. The patient is aware they must meet eligibility criteria of confirmed COVID-19 by an appropriate test and symptomatic for 5 days or less at the time of filling Paxlovid. I have reviewed dosage, possible drug-drug interactions, and medication modifications that may need to be modified while taking Paxlovid.

Physician Signature	Physician Name (Print)	Date Signed
	CPSID	

**FAX INFORMATION**

Pharmacy Name	Pharmacy Fax Number	If this fax is received in error, or you have questions for the prescriber, please call:
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## Clinically extremely vulnerable groups

CEV Group 1 includes severe immunocompromise e.g., solid organ transplant, stem-cell transplant or CAR-T cell therapy, active treatment for hematological malignancies, B-cell depleting and anti-CD 40 therapy

CEV Group 2 includes moderate immunocompromise e.g., solid tumor cancer treatment, active hematological malignancy, immunosuppressive therapy, primary immunodeficiencies and advanced/untreated HIV

CEV Group 3 includes high-risk conditions e.g., cystic fibrosis, severe asthma or severe COPD, diabetes requiring insulin, developmental or intellectual disabilities, rare metabolic or blood disorders and others

Many additional chronic conditions can be considered. Consult Practice Tool #1 – Step by Step Assessment

To be eligible, patient has none of the exclusion criteria listed below:

- History of significant liver disease – cirrhosis, active hepatitis (ALT 5x ULN), or severe liver dysfunction (Child-Pugh C)
- Moderate-severe renal impairment requiring renal replacement therapy or known eGFR less than 30 mL/min
- History of hypersensitivity or other contraindication to any of the components of medication

### \*Covid Clinical Practice Tools:

<http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/treatments>

**Prescriptions can be faxed to community pharmacies. For a list of pharmacies that dispense Paxlovid, please see <https://www.bcpharmacy.ca/paxlovid>**

**NOTE:** B.C. residents who do not meet the above eligibility criteria for Paxlovid may be eligible to participate in a non-profit COVID-19 treatment study. Visit <https://cantreatcovid.org> for details.