BWH QUICK-REFERENCE GUIDE

COVID-19 Drugs & Treatment

For more information on therapeutics, visit https://covidprotocols.org/protocols/therapeutics.
See also: Inpatient, Outpatient, and ICU Patient guides at https://covidprotocols.org/quick-guides

ANTIBIOTICS

- Use only if concerned for bacterial co-infection
  - procalcitonin not reliable in cytokine storm
- Azithromycin: use only if indicated for bacterial infection

ANTICOAGULATION

- Therapeutic AC: if otherwise indicated; currently not recommended for treatment of COVID alone
- Prophylactic AC: given increased VTE risk, COVID ICU patients need higher prophylaxis
  - hold if PLT < 25 K, neurosurgery, hemorrhage, etc.
  - PTT may not be reliable due to coagulopathy, in some patients consider anti-Xa monitoring
    » Goal peak for VTE ppx is between 0.2 and 0.5 (measured 4–6 hours after 3–4 injections)
- outpatients: no prophylaxis unless otherwise indicated, recommend frequent ambulation

Inpatient ppx (normal dose)

<table>
<thead>
<tr>
<th>WEIGHT</th>
<th>CrCl ≥ 30 ml/min</th>
<th>CrCl &lt; 30 ml/min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (&lt; 50 kg)</td>
<td>Enoxaparin 30 mg daily</td>
<td>UFH 5,000 units BID or TID</td>
</tr>
<tr>
<td>Standard</td>
<td>Enoxaparin 40 mg daily</td>
<td>UFH 5,000 units q8h</td>
</tr>
<tr>
<td>Obese (≥120 kg or BMI ≥35)</td>
<td>Enoxaparin 40 mg BID or 0.5 mg/kg daily (max 100 mg daily)</td>
<td>UFH 7,500 units q8h</td>
</tr>
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ICU/post-ICU ppx until discharge (high dose)

<table>
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<th>CrCl ≥ 30 ml/min</th>
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</thead>
<tbody>
<tr>
<td>Low (&lt; 60 kg)</td>
<td>Enoxaparin 30 mg BID</td>
<td>UFH 7,500 units q8h</td>
</tr>
<tr>
<td>Standard</td>
<td>Enoxaparin 40 mg BID</td>
<td>UFH 7,500 units q8h</td>
</tr>
<tr>
<td>Obese (≥120 kg or BMI ≥35)</td>
<td>Enoxaparin 0.5 mg/kg BID (max 100 mg BID)</td>
<td>UFH 10,000 units q8h</td>
</tr>
</tbody>
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ANTI-INFLAMMATORIES / IMMUNOSUPPRESSANTS

Page prescribing physician to discuss before changing home immunosuppression (some can be safely held, others cannot).
- Steroids: recommended if on supplemental oxygen
  - Dexamethasone 6 mg IV or PO daily × 10 days, or alternative equivalents:
    » Hydrocortisone 50 mg IV q8h × 10 days
    » Methylprednisolone 15 mg IV BID × 10 days
    » Prednisone 40 mg PO daily × 10 days
- Anti-IL1, Anti-IL6: do not use unless in consultation with Rheum or Pulmonary
- Hydroxychloroquine: do not use
- NSAIDS: use as normal

ANTI-TUSSIVES AND EXPECTORANTS

- Guaifenesin may help with secretions
- Dextromethorphan, Benzonatate, Codeine for cough

ANTIVIRALS

ID follows inpatients for clinical trials and current Tx. (See Therapeutics Summary at covidprotocols.org)
- Remdesivir recommended if patient meets criteria
- Convalescent Plasma: unclear benefit, likely depends on titer and neutralizing Ab; available under EUA
- Monoclonal Antibodies: consider in early disease
  - At MGB, outpatients with mild to moderate disease, and age ≥ 65 or with BMI ≥ 35, can be entered into lottery for treatment using the order “Amb Referral to Eval for Monoclonal Therapy”
- No convincing evidence for: Interferon, IVIG, Lopinavir/Ritonavir, Ribavirin, Zinc, Vitamin C

BRONCHODILATORS/INHALERS

- Bronchodilators if patient has asthma or COPD, but not routinely indicated for COVID
- Use MDIs if possible (less aerosolizing), treat nebulizers as AGP unless ventilated (in-line closed circuit neb)

INTRAVENOUS HYDRATION

- Conservative boluses as needed (LR preferred) with dynamic measures of response (delta BP, UOP, PPV, CVP)
- Avoid maintenance IVF due to hypoxemia risk

See https://covidprotocols.org/ for current full manual.