



**ORDER SET
Intravenous Therapy for Moderate to Severe COVID-19**

(Version 2. 2022JUL26)

First and Last Name: _____ Allergies: _____

Health Card Number: _____ Date of Birth (YYYY/MON/DD): _____

Items preceded by a **bullet** (•) are active orders. Items preceded by a **checkbox** (☐) are only to be carried out if checked.

Pharmacy Site: _____ Fax Number: _____

Weight _____ kg

1. General

- Treatment must be prescribed by NS Health Moderate – Severe COVID-19 Inpatient Designated Prescriber.

2. Criteria for Use

Remdesivir

- Symptomatic, moderate to severe COVID-19

Tocilizumab

- Symptomatic, severe COVID-19, SpO2 less than or equal to 92 % on room air or supplemental oxygen, and systemic inflammation (e.g. C reactive protein above 75 mg/L)

3. Remdesivir Therapy

Select from the following:

Initiation of Remdesivir Therapy

- ☐ Remdesivir 200 mg IV x 1 on Day 1, then
Remdesivir 100 mg IV daily on Day 2 to Day 5
Day 1 of therapy: _____ (YYYY/MON/DD)

Continuation of Previously Initiated Remdesivir Therapy

- ☐ Remdesivir 100 mg IV daily x _____ more days (maximum total duration of 10 days).

4. Tocilizumab Therapy

- ☐ Tocilizumab (8 mg/kg) _____ mg (rounded to nearest 20 mg) IV x 1 dose (to a maximum 800 mg)

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Authorized Prescriber's Signature: _____ Reg. No.: _____

Authorized Prescriber's Name: _____ Date (YYYY/MON/DD): _____ Time: _____

Print

