### Antiviral Therapy

**Remdesivir** is not recommended outside of approved clinical trials.

Based on the current scientific evidence and best-practice guidelines, the College of Physicians and Surgeons of BC, the College of Pharmacists of BC, the BC College of Nurses and Midwives and the CTC do not approve of the use of remdesivir for either treatment or prophylaxis for COVID-19 and BC registrants must not prescribe it for this purpose. **Remdesivir should not be used outside of approved clinical trials.**

**Dexamethasone** is not recommended in hospital for more than 14 days with symptoms of COVID-19 should not receive Tocilizumab/Sarilumab for this indication. Tocilizumab/Sarilumab should only be initiated when life support is required because of COVID-19 rather than other causes (such as bacterial infection, pulmonary embolism, etc). Tocilizumab or sarilumab should not be combined with baricitinib.

**Tocilizumab** is not recommended for patients receiving low-flow oxygen support. The RECOVERY trial found a survival benefit of 4% (tocilizumab 29% vs. usual care: 33% 28-day mortality) in patients who had CRP >75 mg/L AND low-flow oxygen, non-invasive respiratory support, or invasive mechanical ventilation (on mechanical ventilation: considering the scarcity of L-6 blockers in Canada, drug therapy should be prioritized to the persons with the highest need and the greatest likelihood of benefiting from the therapy. With outstanding findings in the preliminary outcomes of the RECOVERY trial (e.g. 17% of patients randomized to tocilizumab not receiving the drug), the CTC recommends prioritizing tocilizumab use only for critically ill patients at this time, which is the population shown to benefit in both the REMAP and RECOVERY trials.

**Baricitinib** is not recommended in hospitalized COVID-19 patients with fever requiring low-flow oxygen support. Baricitinib should be administered within 24 hours of initiation or change in baseline use of oxygen due to COVID-19 pneumonia (not from other causes such as heart failure, pulmonary emboli, etc). Baricitinib should not be administered if CRP >90 mg/L, lymphocytes <0.5 x 10^9/L or eGFR <30 mL/min (or 2 mg PO every 2nd day for GFR 60-59 mL/min).

**Monoclonal antibodies** (mAbs; Bamlanivimab/etesevimab, REGEN-COV, Sotrovimab, Regdanivab) are not recommended. An RCT of REGEN-COV in this population was halted due to signals of harm. Regdanivab and REGEN-COV conditions for use state that it may be associated with worse outcomes in the critically ill. RECOVERY showed no benefit in the subgroup that required organ support. Various guidelines (INDS, NI, INESSS) recommend against the use of remdesivir.

**Colchicine** and other biologics (e.g., anakinra) are not recommended outside of approved clinical trials.

### Immunomodulatory Therapy

**Dexamethasone** is not recommended in hospital for more than 14 days with symptoms of COVID-19 should not receive Tocilizumab/Sarilumab for this indication. Tocilizumab/Sarilumab should only be initiated when life support is required because of COVID-19 rather than other causes (such as bacterial infection, pulmonary embolism, etc). Tocilizumab or sarilumab should not be combined with baricitinib.

**Tocilizumab** is not recommended for patients receiving low-flow oxygen support. The RECOVERY trial found a survival benefit of 4% (tocilizumab 29% vs. usual care: 33% 28-day mortality) in patients who had CRP >75 mg/L AND low-flow oxygen, non-invasive respiratory support, or invasive mechanical ventilation (on mechanical ventilation: considering the scarcity of L-6 blockers in Canada, drug therapy should be prioritized to the persons with the highest need and the greatest likelihood of benefiting from the therapy. With outstanding findings in the preliminary outcomes of the RECOVERY trial (e.g. 17% of patients randomized to tocilizumab not receiving the drug), the CTC recommends prioritizing tocilizumab use only for critically ill patients at this time, which is the population shown to benefit in both the REMAP and RECOVERY trials.

**Baricitinib** is not recommended in hospitalized COVID-19 patients with fever requiring low-flow oxygen support. Baricitinib should be administered within 24 hours of initiation or change in baseline use of oxygen due to COVID-19 pneumonia (not from other causes such as heart failure, pulmonary emboli, etc). Baricitinib should not be administered if CRP >90 mg/L, lymphocytes <0.5 x 10^9/L or eGFR <30 mL/min (or 2 mg PO every 2nd day for GFR 60-59 mL/min).

**Monoclonal antibodies** (mAbs; Bamlanivimab/etesevimab, REGEN-COV, Sotrovimab, Regdanivab) are not recommended. An RCT of REGEN-COV in this population was halted due to signals of harm. Regdanivab and REGEN-COV conditions for use state that it may be associated with worse outcomes in the critically ill. RECOVERY showed no benefit in the subgroup that required organ support. Various guidelines (INDS, NI, INESSS) recommend against the use of remdesivir.

**Colchicine** and other biologics (e.g., anakinra) are not recommended outside of approved clinical trials.

### Summary

- **Antiviral Therapy**
  - Remdesivir is not recommended outside of approved clinical trials.
  - Dexamethasone is not recommended in hospital for more than 14 days with symptoms of COVID-19 should not receive Tocilizumab/Sarilumab for this indication. Tocilizumab/Sarilumab should only be initiated when life support is required because of COVID-19 rather than other causes (such as bacterial infection, pulmonary embolism, etc). Tocilizumab or sarilumab should not be combined with baricitinib.

- **Immunomodulatory Therapy**
  - Tocilizumab is not recommended for patients receiving low-flow oxygen support. The RECOVERY trial found a survival benefit of 4% (tocilizumab 29% vs. usual care: 33% 28-day mortality) in patients who had CRP >75 mg/L AND low-flow oxygen, non-invasive respiratory support, or invasive mechanical ventilation (on mechanical ventilation: considering the scarcity of L-6 blockers in Canada, drug therapy should be prioritized to the persons with the highest need and the greatest likelihood of benefiting from the therapy. With outstanding findings in the preliminary outcomes of the RECOVERY trial (e.g. 17% of patients randomized to tocilizumab not receiving the drug), the CTC recommends prioritizing tocilizumab use only for critically ill patients at this time, which is the population shown to benefit in both the REMAP and RECOVERY trials.
  - Baricitinib is not recommended in hospitalized COVID-19 patients with fever requiring low-flow oxygen support. Baricitinib should be administered within 24 hours of initiation or change in baseline use of oxygen due to COVID-19 pneumonia (not from other causes such as heart failure, pulmonary emboli, etc). Baricitinib should not be administered if CRP >90 mg/L, lymphocytes <0.5 x 10^9/L or eGFR <30 mL/min (or 2 mg PO every 2nd day for GFR 60-59 mL/min).
  - Monoclonal antibodies (mAbs; Bamlanivimab/etesevimab, REGEN-COV, Sotrovimab, Regdanivab) are not recommended. An RCT of REGEN-COV in this population was halted due to signals of harm. Regdanivab and REGEN-COV conditions for use state that it may be associated with worse outcomes in the critically ill. RECOVERY showed no benefit in the subgroup that required organ support. Various guidelines (INDS, NI, INESSS) recommend against the use of remdesivir.
  - Colchicine and other biologics (e.g., anakinra) are not recommended outside of approved clinical trials.

- **Therapeutic Anticoagulation**
  - Prophylactic-intensity dosing of low molecular weight heparin (LMWH) is recommended for VTE prophylaxis in patients who do not have suspected or confirmed VTE (or other indications for therapeutic anticoagulation). There is a high probability of harm when therapeutic anticoagulation is initiated in patients who have received organ support for greater than 48 hours (i.e.<1076.8 NIH CTAST). Patients receiving therapeutic anticoagulation prior to organ support should REMAIN on therapeutic anticoagulation and continue for up to 14 days or until hospital discharge.

- **NSAIDs**
  - Should not be discontinued solely on the basis of COVID-19.

- **ACE inhibitors and ARBs**
  - Should not be discontinued solely on the basis of COVID-19.