## SEVERITY OF ILLNESS

<table>
<thead>
<tr>
<th>Critically Ill Patients</th>
<th>Severely Ill Patients</th>
<th>Moderately Ill Patients</th>
<th>Mildly-Ill or with Mild Co-Morbidities</th>
<th>Discharge</th>
<th>Prophylaxis</th>
</tr>
</thead>
<tbody>
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<td>Hospitalized, ICU-based</td>
<td>Hospitalized, ward-based, long-term care</td>
<td>Patients requiring supplemental oxygen therapy</td>
<td>Patients requiring respiratory support (high-flow oxygen, noninvasive mechanical ventilation) and/or vasopressor/ inotropic support</td>
<td>Patients who have recovered and are discharged from hospital</td>
<td>Antiviral agents and immunomodulatory therapy against COVID-19 are recommended among health-care workers and other high-risk settings, but are not recommended in the community setting. The use of remdesivir for prophylaxis in COVID-19 and BC registrants must not be used outside of approved clinical trials.</td>
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## ANTI-VIRAL 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 and the College of Pharmacists of BC, the College of Physicians of BC, the BC College of Nurses and Midwives and the CTC do not approve of the use of remdesivir for prophylaxis of COVID-19 and BC registrants must not be used outside of approved clinical trials.

- **Tocilizumab**: is recommended for patients requiring life support due to confirmed COVID-19. This includes high-flow oxygen support (e.g., Optiflow) if flow rate > 30 L/min and FiO₂ > 0.4 for OR invasive or non-invasive ventilation OR vasopressor or inotropic support.

- **Baricitinib**: is recommended for patients requiring respiratory support (e.g., high-flow oxygen, non-invasive ventilation, mechanical ventilation) and/or vasopressor/ inotropic support. Baricitinib should be initiated within 24 hours of the initiation of life support measures. Patients receiving baricitinib prior to becoming critically ill may stop baricitinib and be switched to a one-time dose of an IL-6 inhibitor. There is no evidence to co-administer IL-6 inhibitors with baricitinib.

- **Tocilizumab 400 mg IV (single dose)**: is recommended (REMAP-CAP, RECOVERY). Patients admitted to 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

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

- **Monoclonal antibodies (mAbs)**: Bamlanivimab/etesevimab, REGEN-COV, Sotrovimab, Regdanivamab are not recommended. An mAb of REGEN-COV is in a comparator trial, in which this population was killed due to signals of harm. Regdanivamab 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 (IDSA, NIH, INESS) recommend against mAbs in this setting.

## OTHER THERAPIES

- **Therapeutic anticoagulation (LWMH preferred)**: is recommended in patients with high-risk features for venous thromboembolic complications. Due to resistance of Omicron to these agents. Due to lack of impact on the current SARS-CoV-2 variants, anticoagulation for COVID-19 should start within 72 hours of hospital admission. Patients who require and are discharged from hospital anticoagulation while on therapeutic anticoagulation should continue on therapeutic anticoagulation. Therapeutic anticoagulation was superior to standard of care for improving mortality and hospital-free survival in the ATTACC-Act/4L-REMAP-CAP trials. Benefits appear to be driven by reducing progression to high-flow oxygen, non-invasive ventilation, or vasopressors. There was insufficient certainty on whether therapeutic anticoagulation improves mortality or intubation. Therapeutic anticoagulation reduces thrombotic events (3.4% vs 2.5%) but may increase major bleeding (1.5% vs 0.9%).

- **ACE inhibitors and ARBs**: should not be discontinued solely on the basis of COVID-19 NSAIAs should not be discontinued solely on the basis of COVID-19