**SEVERITY OF ILLNESS**

**CRITICALLY ILL PATIENTS**
- ICU-admitted, COVID-19-confirmed
- Patients requiring respiratory support (high-flow oxygen, noninvasive mechanical ventilation) and/or vasopressor/inotropic support

**SEVERELY ILL PATIENTS**
- Hospitalized, high-risk, long-term care
- Patients requiring supplemental oxygen therapy

**MODERATELY ILL PATIENTS**

**DISCHARGE**
- Patients that have recovered and are discharged from hospital

**PROPHYLAXIS**
- Asymptomatic patients with known COVID-19 exposure

**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 prophylaxis of COVID-19 and BC registrants must not prescribe it for this purpose. Remdesivir should not be used outside of approved clinical trials.

- **Dexamethasone** 6 mg IV/SC/PO q24h for up to 10 days is strongly recommended (RECOVERY trial), unless higher doses are clinically indicated.
- Hydrocortisone 50 mg IV q6h is recommended as an alternative (REMAP-CAP trial). If dexamethasone and hydrocortisone are not available, methylprednisolone 32 mg IV q24h or prednisone 40 mg PO daily are recommended.
- *e.g., asthma exacerbation, refractory septic shock, history of chronic steroid use, obstetric use for fetal lung maturation

- **Tocilizumab, Sarilumab OR Baricitinib** 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 OR invasive or non-invasive ventilation OR vasopressor or inotropic support. Tocilizumab should be administered within 24 hours of non-invasive ventilation. While head-to-head comparative data are lacking, the magnitude of benefit of both agents appears equivalent. However, more robust data exist to support the use of tocilizumab and sarilumab. Tocilizumab also carries the additional challenges related to gastric access and cytotoxic precautions. The ultimate choice of agent depends on patients’ risks and practical considerations and 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)** OR Sarilumab 400 mg IV (single dose) is recommended (REMAP-CAP, RECOVERY). Patients admitted to hospital for more than 14 days without symptoms 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 OR

- **Baricitinib** 4 mg PO daily (for GFR ≥ 60 mL/min) or 2 mg PO daily (for GFR 30-59 mL/min) or 2 mg PO every 2nd day (for GFR 15-29 mL/min) up to 14 days, or until discharge from hospital (whichever occurs first) is recommended (COV-BARRIER, RECOVERY). Baricitinib should only be initiated in patients with neutrophils < 1.0 giga/L, lymphocytes < 0.2 giga/L, ALT or AST > 5 x ULN, or eGFR < 15 mL/min (or receiving renal replacement therapy). Baricitinib should not be combined with tocilizumab or sarilumab. *Limited data exist in baricitinib in pregnancy. Risks and benefits of baricitinib should be discussed on a case-by-case basis with pregnant women with severe COVID-19

**IMMUNOMODULATORY THERAPY**

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

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

**OTHER THERAPIES**

- **Prophylactic-intensity dosing of low molecular weight heparin (LMWH)** is recommended. There is strong evidence that 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 (n=10764, NIH-REACT). Patients receiving therapeutic anticoagulation for COVID-19 prior to organ support should remain on therapeutic anticoagulation and continue for up to 14 days or until hospital discharge.

- **Antibiotic therapy is not routinely recommended** for the treatment of COVID-19 pneumonia. If bacterial co-infection is suspected, follow local practice guidelines for CAP, HAP and VAP.

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

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

**NOT RECOMMENDED FOR ANY SEVERITY**

- **Convalescent Plasma, IVlg, chloroquine or hydroxychloroquine, lopinavir/ritonavir, interferon IV** and SC and ribavirin have been evaluated across all disease severity but have not been found to be effective against COVID-19 in clinical trials, or high-quality clinical trials are lacking. These agents are not recommended for prevention or treatment of COVID-19 across all disease severities.