

(Nirmatrelvir-Ritonavir) Paxlovid™ Prescription

MUST include accurate medication list with Form

Please fax completed form AND patient's medication list to patient's preferred pharmacy

Prescriber Information		Patient Information			
First Name	Last Name	First Name	Last Name	Sex (at birth) <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
Address		Address		Health Card No. . .	Version
		City		Postal Code	
City	Postal Code	Telephone		Preferred Language <input type="checkbox"/> EN <input type="checkbox"/> Other	
Telephone	Fax	Height (cm)		Weight (Kg)	

Date of positive COVID test:	Date of symptom onset (day zero is first day of symptoms) (must be 5 days or less):	
Screening Eligibility: (Check all that apply)		
<input type="checkbox"/> 60 years of age, or older	<input type="checkbox"/> Over 18 and immunocompromised	<input type="checkbox"/> 18-59:
<input type="checkbox"/> Drug Therapy/Medication Name (if applicable):	<input type="checkbox"/> who have one or more comorbidity that puts them at higher risk of severe COVID-19 disease	
	<input type="checkbox"/> unvaccinated (and therefore at an elevated risk of severe COVID-19 infection)	
	<input type="checkbox"/> has not completed their primary series of COVID-19 vaccination	
	<input type="checkbox"/> has not had a COVID-19 vaccine dose or COVID-19 infection in the last 6 months	

(Nirmatrelvir-Ritonavir) Paxlovid™ Assessment:	
<input type="checkbox"/> Attach current medication, herbal, OTC list	Existing liver impairment: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
<input type="checkbox"/> Patient's home pharmacy	Existing renal impairment: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
<input type="checkbox"/> Home pharmacy phone number	If YES, enter Serum Creatinine and eGFR if available
<input type="checkbox"/> Allergies <input type="checkbox"/> NKA	<input type="checkbox"/> Serum Creatinine (µmol/L): _____ Date: _____
Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> eGFR (ml/min): _____ Date: _____
<i>Pharmacist will review eligibility, assess drug interactions and confirm dosing prior to releasing the medication. Any recommended changes to the therapeutic regimen will be communicated back to the prescriber.</i>	

Medication Order
Standard Dose (eGFR above 60ml/min)
<input type="checkbox"/> Paxlovid (Nirmatrelvir 150mg and Ritonavir 100mg): Take 2 pink tablets of nirmatrelvir and 1 white tablet of ritonavir once in the morning and once in the evening for 5 days
Reduced Dose (eGFR between 30-59ml/min)
<input type="checkbox"/> Paxlovid (Nirmatrelvir 150mg and Ritonavir 100mg): Take 1 pink tablet of nirmatrelvir and 1 white tablet of ritonavir once in the morning and once in the evening for 5 days
Reduced Dose (eGFR less than 30 mL/min) (off-label use, Paxlovid -What Pharmacists and Prescribers Need to Know (December 14, 2022))
<input type="checkbox"/> Day 1: Nirmatrelvir 300 mg and ritonavir 100 mg, Days 2-5: Nirmatrelvir 150 mg and ritonavir 100 mg once daily.
<input type="checkbox"/> Dialysis: Dose for eGFR less than 30 mL/min; give after dialysis.
<input type="checkbox"/> If dialysis and weight less than 40 kg: Nirmatrelvir 150 mg and ritonavir 100 mg q48h x 3 doses; give after dialysis.
Additional Medication Changes:

By prescribing this medication, the referring prescriber assumes responsibility for all follow up.

Physician/NP/Pharmacist Registration Number

Signature

Date

Prescriber Direct Contact Phone Number