PHARMACIST INITIATED TREATMENT OF COVID-19

PAXLOVID (NIRMATRELVIR, RITONAVIR)

Fax requests to (902) 368-4905, email to drugprograms@gov.pe.ca **OR** mail requests to PEI Pharmacare, P.O. Box 2000, Charlottetown, PE, C1A 7N8

SECTION 1 – PRESCRIBER INFORMATION	SECTION 2 – PATIENT INFORMATION	
NAME AND MAILING ADDRESS	PATIENT (FAMILY NAME)	PATIENT (GIVEN NAME)
	DATE OF BIRTH (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)
PHONE NUMBER (INCLUDE AREA CODE):	PATIENT'S MAILING ADDRESS	
FAX NUMBER (INCLUDE AREA CODE):		

ELIGIBILITY CRITERIA (PLEASE CHECK APPLICABLE PATIENT INFORMATION):

☐ Mild to moderate coronavirus disease (COVID-19) in adult patients who are within 5 days of:

- Symptom onset; AND   Date of symptom onset: _____
- Positive COVID-19 test.   Date of COVID-19 test: _____

AND have either of the following:

- **Severely immunosuppressed** due to one or more of the following conditions:
  ☐ Solid organ transplant
  ☐ Receiving treatment for a malignant hematologic condition
  ☐ Bone marrow transplant, stem cell transplant or transplant-related immunosuppressant use
  ☐ Received an anti-CD20 therapy or B-cell depleting therapy (such as rituximab) in the previous two years
  ☐ Severe primary immunodeficiencies

  OR

- **Moderately immunosuppressed** due to one or more of the following conditions:
  ☐ Receiving treatment for cancer, including solid tumors
  ☐ Receiving treatment with significantly immunosuppressing drugs (e.g., biologic in the past three months, oral immune-suppressing drug in the past month, oral steroid [20 mg per day of prednisone equivalent taken on an ongoing basis] in the past month, or immune-suppressing infusion or injection in the past three months)
  ☐ Advanced HIV infection
  ☐ Moderate primary immunodeficiencies
  ☐ Renal conditions (i.e., hemodialysis, peritoneal dialysis, glomerulonephritis treated with a steroid, eGFR less than 15 mL/min/1.73m^2)

Requests for patients who are moderately or severely immunosuppressed due to other conditions may be considered by Pharmacare.

CONFIRMATION OF PROGRAM ELIGIBILITY (PATIENT IS ENROLLED IN AN ELIGIBLE DRUG PROGRAM):

☐ Seniors   ☐ Financial Assistance   ☐ Family Health Benefit   ☐ Catastrophic   ☐ Nursing Home

- Confirmation of coverage should be established through means of electronic adjudication to Pharmacare.
- Manual claims for coverage or retroactive coverage will not be considered.

NIRMATRELVIR /RITONAVIR (PAXLOVID) PRODUCT SELECTION:

☐ 300/100 mg PO BID x 5 days   ☐ 150/100 mg (Paxlovid Renal) PO BID x 5 days
☐ Alternate Dose Adjustments: DOSE: _____ FREQUENCY: _____ DURATION:_____

ADDITIONAL INFORMATION RELATED TO REQUEST:

NOTES:

- Paxlovid is only eligible for coverage under certain Pharmacare drug programs. Patients are responsible for the associated copayment and must be enrolled in an eligible drug program.
- Pharmacists must verify eligibility criteria above prior to dispensing and provide a copy of this form to Pharmacare for records.

PRESCRIBER SIGNATURE (REQUIRED)   **DATE**

FORMS WITH INFORMATION MISSING WILL BE RETURNED FOR COMPLETION.
APPROVALS WILL NOT BE CONSIDERED AT DOSES OR DOSING INTERVALS OUTSIDE OF PEI GUIDELINES   MAY 2024/JC