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UCDH Adult COVID-19 Treatment Guidelines

DISEASE SEVERITY	INFECTIOUS DISEASE RECOMMENDATIONS
Not Hospitalized	• **Recommend against** the use of Dexamethasone. • If all below criteria are met, consider **EUA monoclonal antibodies** (through outpatient monoclonal antibody therapy workflows) - No indication for admission - Mild-moderate disease w/ <10 days of influenza-like illness symptoms (no O2 requirement) - 1+ of the following risk factors: Age > 64, immunocompromised, COPD, HTN/CVD, CKD, DM, BMI > 34, pregnancy
Hospitalized + NO Supplemental Oxygen	• Prioritize clinical trial enrollment. Contact ID Clinical Trial coordinator to see if eligible (see COVID Clinical Trials criteria) • **Recommend against** the use of Dexamethasone. • If symptom onset < 10-14 days AND high risk for progression to severe disease (multiple risk factors for severe disease +/- CXR findings), **start Remdesivir** x 5 days at dose and duration discussed below.
Hospitalized + Supplemental Oxygen (Not HFNC, Non-Invasive Ventilation, Mechanical Ventilation, or ECMO)	• Prioritize clinical trial enrollment. Contact ID Clinical Trial coordinator to see if eligible (see COVID Clinical Trials criteria) • **Start Remdesivir** 200mg IV for one day followed by **Remdesivir** 100mg IV once daily for 4 days or until hospital discharge, whichever comes first. Extending duration to 10 days in the setting of no clinical improvement should be done in consultation with ID. Most benefit if started within 10-14 days of symptom onset. Consider risks/benefits of starting Remdesivir if creatinine clearance < 30 mL/min (can discuss with ID or ID pharmacy). *Not contraindicated in RRT.* • If progressive hypoxia or ≥ 3L/min NC, **add Dexamethasone** 6mg IV or PO daily for up to 10 days or until hospital discharge, whichever comes first. • May consider **adding Dexamethasone** if stable disease on ≤ 2L/min AND patient has multiple risks for severe disease. • **Baricitinib** may be considered as an alternative to Dexamethasone if there are contraindications to steroid use (i.e. DKA)
Hospitalized + HFNC or Non-Invasive Ventilation	• Prioritize clinical trial enrollment. Contact ID Clinical Trial coordinator to see if eligible (see COVID Clinical Trials criteria) • Use one of the following options: • **Dexamethasone** plus **Remdesivir** at the doses and durations discussed above (if < 14 days of symptom onset) • **Dexamethasone** alone at dose and duration discussed above (e.g., when combination therapy with Remdesivir cannot be used) • If admitted within 24 hours (or within 48 hours w/ rapid progression) add, in combination w/ Dexamethasone, **give Tociluzimab x 1** • 8mg/kg IV one time by IBW (max dose 800mg) • Exclusion criteria: immunomodulating drugs, AST or ALT > 5x ULN, ANC < 500, plts < 50,000, hi risk of GI perf, hi suspicion bacterial or fungal infection
Hospitalized + Mechanical Ventilation or ECMO	• Start **Dexamethasone** at the dose and duration discussed above • If admitted within 24 hours and no exclusion criteria met add, in combination with Dexamethasone, **Tocilizumab** at the dose discussed above • No evidence to support using Remdesivir in this population; however, if ≤7 days of symptoms OR patient had been started on an alternate form of supplemental oxygen within the past 24h (NC, HFNC, or NIV) could consider addition of **Remdesivir** in consultation with ID.
Immunocompromised	• For the severely immunocompromised (heme-malignancy, SCT, SOT, HIV/AIDS, etc) **consider ID consultation** for additional guidance

- For therapeutic questions or for patients who may benefit from therapies outside this guidance, contact the "COVID-19 Therapeutics" Attending found in the On-Call schedule.
- **PCR-NEGATIVE BUT HIGH COVID SUSPICION:** A single FDA emergency use authorized SARS-CoV-2 PCR test detects >85-90% of those infected. Variation is due to timing of test during course of illness, sample quality, etc. In the setting of a negative test in high-suspicion cases (without clear alternative diagnosis) it is ***strongly*** recommended to keep patient in isolation & repeat testing in 24h.
- Early in disease, bacterial co-infections with COVID-19 are rare (~3%). Antibiotics in mild-moderate COVID-19 disease are usually not necessary.