CommonSpirit

COVID-19 Outpatient Medication Stewardship Guidance for Retail and Clinic Pharmacists and Providers

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Current State:

- Medications to treat COVID-19 are **currently on shortage or may become short in the near future.**
- If patients are well enough to discharge, it is not necessary to continue COVID-19 directed therapy (unless patients are enrolled in a clinical trial).
- There is no data to support using hydroxychloroquine or chloroquine for prophylaxis.

General patient care treatment guidance:

- Patients diagnosed with pneumonia with suspected COVID-19 infection should begin community acquired pneumonia (CAP) treatment until COVID-19 is confirmed.
- CDC recommends supportive care as best care in COVID-19 infected patients in the outpatient setting.

Medication specific treatment guidance:

Hydroxychloroquine / chloroquine	• Use for COVID-19 treatment is based on limited emerging data. • For most cases, evidence does not support use in patients well enough to be treated at home.
Azithromycin	• There is insufficient evidence for use in outpatient treatment of COVID-19. • Use may continue for other indications (e.g., COPD exacerbation).
Kaletra (lopinavir-ritonavir)	• In a recent in vivo study, it did not show benefit compared to standard of care. Additional studies are ongoing, including those with combination therapy.
Ribavirin	• There is no evidence to support ribavirin monotherapy as a treatment for COVID-19 at this time.
Oral steroids	• Oral steroids should be avoided, if possible, for COVID-19, because of the potential for prolonging viral replication as observed in MERS-CoV patients, unless indicated for other indications, such as COPD, asthma, etc.
General inhaled treatment	• If needed for non-COVID-19 indications, administer inhaled (by mouth or nasal) medications in the patient's home setting in a closed room away from other people to minimize exposure.
Beta agonist and anticholinergic inhaled treatment	• Carefully assess each person under investigation (PUI) or known COVID-19 positive patient prior to ordering any inhaled therapy. ○ NOTE: The American Association of Respiratory Care SARS CoV-2 Guidance Document states that there is no role for inhaled bronchodilation in patients with COVID-19 unless the patient has co-morbid asthma or COPD. • Reserve albuterol for PUI or COVID-19 positive patients with known asthma and clinical signs of bronchospasm (wheezing). • Reserve ipratropium for PUI or COVID-19 positive patients with COPD.
NSAIDs	• Per the FDA, there is not enough scientific evidence to link the use of NSAIDs to worsening symptoms of COVID -19. However, until further information is available, utilize acetaminophen first line for fevers, if no contraindications are present. Please note, that not all fevers need to be brought to normothermia.
ACE inhibitors and ARBs	• The HFSA, ACC, and AHA recommend continuation of RAAS (renin-angiotensin-aldosterone system) antagonists for those patients who are currently prescribed such agents for indications for which these agents are known to be beneficial, such as heart failure, hypertension, or ischemic heart disease. Currently there are no experimental or clinical data demonstrating beneficial or adverse outcomes with background use of ACE inhibitors, ARBs or other RAAS antagonists in

	COVID-19 or among COVID-19 patients with a history of cardiovascular disease treated with such agents.

Prescription guidance:

- Limit hydroxychloroquine, chloroquine, and lopinavir/ritonavir (Kaletra®) to a one month supply on patients for continuation of established therapy for documented rheumatological disease or HIV infection
- Valid prescription will include diagnosis documentation of new chronic rheumatological disease or HIV infection.
- If hydroxychloroquine or chloroquine is written for COVID-19 prophylaxis, discuss with the provider the lack of data to utilize for this. Convey that it is inappropriate at this time. It should not be dispensed.
- Azithromycin therapy for CAP should not exceed 5 days.

References

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