NATIONAL CLINICAL EVIDENCE TASKFORCE
COVID-19

DRUG TREATMENTS FOR AT RISK ADULTS WITH COVID-19 WHO DO NOT REQUIRE OXYGEN

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Adult with symptomatic COVID-19 who does not require oxygen and has one or more risk factors for disease progression

START HERE

Risk factors for disease progression

- Older age (e.g. over 65 years, or over 50 years for Aboriginal and Torres Strait Islander people)
- Diabetes requiring medication
- Obesity (BMI >30 kg/m^2)
- Renal failure
- Cardiovascular disease, including hypertension
- Respiratory compromise, including COPD, asthma requiring steroids, or bronchiectasis
- See also immunocompromising conditions

Immunocompromising conditions

Primary or acquired immunodeficiency
- **Haematologic neoplasms:** leukaemias, lymphomas, myelodysplastic syndromes
- **Post-transplant:** solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)
- **Immunocompromised due to primary or acquired (AIDS) immunodeficiency**
- **Other significantly immunocompromising conditions**

Immunosuppressive therapy (current or recent)
- **Chemotherapy,** whole body radiotherapy or total lymphoid irradiation
- **High-dose corticosteroids** (≥ 20 mg of prednisone per day, or equivalent) for ≥ 14 days
- **Selected other potent immunosuppressive therapies** (refer to ATAGI advice)

This decision aid is not intended for pregnant or breastfeeding women.

For complete summaries of treatment recommendations, refer to:

Drug treatments for adults with COVID-19

Drug treatments for pregnant or breastfeeding women with COVID-19

Click to view

Is the patient:

Immunocompromised or unvaccinated?

NO → Is the patient:

At particularly high risk of severe disease on the basis of advanced age, multiple risk factors, and vaccination status (including number of doses and time since last dose, or timing of most recent infection)?

NO → **Risk Classification Tool** (Click to view)

NO → **Treat symptoms and observe.**

Refer to clinical flowcharts for:

Management of adults with mild COVID-19 (Click to view)

or

Management of adults with moderate to severe COVID-19 (Click to view)

YES → Is the patient:

Within 5 days of symptom onset?

NO → Is the patient:

Within 7 days of symptom onset?

NO → Is the patient:

Within 14 days of symptom onset?

NO → **Treat symptoms and observe.**

YES → **Are inhaled cortico-steroids accessible and no absolute or relative contraindications?**

YES → Consider **Inhaled corticosteroids (budesonide or ciclesonide)**

NO → **Is remdesivir accessible and the patient has no relative or absolute contraindications?**

NO → **Are one or more treatments accessible and the patient has no relative or absolute contraindications?**

YES → **There are no studies directly comparing these treatment options and their relative effectiveness is unclear. Inhaled corticosteroids (budesonide or ciclesonide) can be considered for adjunctive use with other treatment options; however, the added benefit of adjunctive use is unclear. There is currently no evidence available on the effectiveness of concurrent use of monoclonal antibodies or antivirals for COVID-19, except where co-formulated.**

YES → Consider
remdesivir
200 mg IV on day 1 then 100 mg IV on days 2 & 3

YES → **Paxlovid prescribing guide** (Click to view)

Consider
nirmatrelvir plus ritonavir (Paxlovid)
300 mg /100 mg PO bd for 5 days

	Antiviral (dual therapy)	Antiviral (monotherapy)
Clinical evidence:	Adults in the EPIC-HR trial were treated within 5 days of symptom onset with oral nirmatrelvir/ ritonavir 300mg/100 mg twice daily for 5 days	Adults in the PINETREE trial were treated within 7 days of symptom onset with three intravenous doses on consecutive days (200 mg on day 1, followed by 100 mg on days 2 and 3)
Administration considerations:	Nirmatrelvir (two 150 mg tablets) and ritonavir (one 100 mg tablet) should be taken together orally every 12 hours for 5 days, with or without food. See full TGA PI	Remdesivir should be administered intravenously in healthcare facilities in which patients can be monitored very closely. See full TGA PI
Contraindications:	Severe renal or severe hepatic impair-ment. Concomitant use with drugs that are highly dependent on CYP3A for clear-ance or are potent CYP3A inducers. Hypersensitivity to active ingredients or other components of the product.	Hypersensitivity to active ingredients or other components of the product.
Drug interactions:	Multiple significant drug-drug interac-tions associated with CYP3A inhibition. See full TGA PI . See Liverpool interaction checker.	Do not use concomitantly with chloroquine phosphate or hydroxychloroquine sulphate.
Pregnancy and conception:	Category B3. Do not use in pregnant women unless eligible to be enrolled in trials. Women of childbearing potential should avoid becoming pregnant during treatment and until 7 days after stopping treatment.	Category B2. Should only be used during pregnancy if the expected benefit to the mother justifies the potential risk to the fetus. Women of childbearing potential must use effective contraception during treatment.
Breastfeeding:	Do not use in breastfeeding women unless eligible to be enrolled in trials. Breastfeeding can commence 7 days after the last dose.	Developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for therapy and any potential adverse effects on the breastfed child.

Notes:

- Molnupiravir should not be used routinely for the treatment of COVID-19. Click here for further information.
- Do not routinely use the following monoclonal antibodies for the treatment of COVID-19:
  - casirivimab plus imdevimab (Ronapreve)
  - sotrovimab (Xevudy)
  - regdanvimab (Regkirona)
  - tixagevimab plus cilgavimab (Evusheld)

  **It is unlikely that tixagevimab plus cilgavimab (Evusheld) is effective in treating individuals with currently circulating variants of COVID-19. Use may be considered for people infected with known Omicron BA2.