Last updated: September 17, 2025

Referral for Outpatient Remdesivir for COVID-19

EMAIL COMPLETED FORM TO: ConnectedCareHub@uhn.ca or fax 416-340-4135

Referral form may not be processed if all sections are not completed.

IMPORTANT: In order to qualify for start of treatment, patients need to a) Be within 7 days of symptom onset b) Meet criteria for use c) Be able to receive three days of consecutive IV therapy in clinic (in home, by exception).

Patient Demographics & History	
Full Name:	**MRN** *(if available)*:
Date of Birth:	**Patient HCN** *(include Version Code)*:
Address:	
Phone Number:	**Email:**
Allergies:	**OR** ☐ **No known allergies**
Patient has a history of serious adverse or allergic reaction to the prescribed medication or related compound?	☐ Yes ☐ No
Brief medical history & current medication list (prescription, non-prescription, over the counter and herbal) *Where applicable, documentation with this information can be attached*	☐ See clinical note below (page 3) ☐ Patient reviewed for drug-drug interaction
Criteria for Use	
Date of Symptom Onset:	**Date of Positive Test:**
Test Type:	☐ PCR Test ☐ Rapid Antigen Test ☐ Rapid Molecular Test
Prescriber acknowledges Ontario Health (OH) & MOH guidelines have been met:	☐ Yes ☐ No

Please select the eligibility criteria the patient meets:
(see Recommendations for Antiviral Therapy for Adults with Mild to Moderate COVID-19 for more information)

☐ **Adults ≥65 years of age with no other risk factors (regardless of vaccination status)**

☐ **Immunocompromised adults ≥18 (regardless of vaccination status or prior infections).** Examples:

- active hematological malignancy or post stem cell transplant or CAR T-cell therapy in last 6 months
- solid organ transplant
- hypogammaglobulinemia
- taking prednisone greater than 20 mg/day (or equivalent) for more than 14 days
- other moderately or severely immunosuppressive therapies (example: anti-CD20 agents, alkylating agents, cancer chemotherapy)

☐ **Adults at increased risk due to one or more medical conditions or risk factors**

- Have never received a COVID-19 vaccine
- Medical Conditions (e.g. Chronic kidney, lung or liver diseases; Diabetes mellitus, type 1 or type 2; disabilities and developmental delay; Heart conditions; Mental health conditions ; Obesity (body mass index above 30 kg/m2); Pregnancy or recent pregnancy)

Patient Demographics & History

Full Name:	**Date of Birth:**
Patient HCN (include Version Code):	

Criteria for Use (cont'd)

Renal Function	**Creatinine umol/L:**	**eGFR:**	☐ **Not Available**
	Please specify reason for approval: *(Note: no dose adjustment required with impaired renal function, including patients on dialysis)*		
Liver Function	**ALT:** **ALP:** **Bili:** **Date:**		☐ **Not Available**
	INR: **Date:**		☐ **Not Available**

Complex patient requiring consultation by ID:	☐ Yes ☐ N/A	If yes, ☐ See clinical note/documentation attached ID Physician Consulted:

Patient willing to travel to receive treatment (three consecutive days):	☐ Yes	☐ No

For patients receiving a First Dose

Is patient on beta-blockers?	☐ Yes	☐ No

Please note: as per the latest OH guidelines, there are no contraindications for patients on beta blockers and the benefit of Remdesivir treatment outweighs the risk

Remdesivir Prescription

Remdesivir LU Code: 722

Remdesivir Prescription (no dose adjustments required for eGFR less than 30 per advisement by Infectious Diseases physicians):

☐ Remdesivir 200mg IV day 1, followed by Remdesivir 100mg IV on Day 2, & Remdesivir 100mg IV on Day 3

☐ Remdesivir 100mg IV on Day 2 and Remdesivir 100mg IV on Day 3
(day 1 already completed on: *[Date & Time]*)

☐ IV Remdesivir:

NOTE: Administer Remdesivir per institution/clinic policy. No refills. Remdesivir must be given over three consecutive days, unless otherwise indicated.

Dose Adjustments (please note if there are any medications being held or adjusted below):

Hold for days from starting Remdesivir

NOTE: This prescription is only for Remdesivir and not intended for any other medications. Please fill out a separate prescription if your patient requires additional medications

Administration Orders

☐ Insert saline lock – discontinue after treatment is complete

☐ Saline lock in place – discontinue after treatment is complete

Prescriber Attestation

☐ I affirm that the patient meets the above criteria for use and appropriate assessment has been completed.

Physician/NP Name:		**Phone Number:**
Email:		**CPSO#:**
Physician/NP Signature:		**Date:**

Patient Demographics & History	
Full Name:	**Date of Birth:**
Patient HCN (include Version Code):	
Remdesivir Clinical Note and Medication List	