Several therapeutic options are now available to treat nonhospitalized adults with mild to moderate COVID-19 who are at high risk of disease progression. Several factors affect the selection of the best treatment option for a specific patient. These factors include the clinical efficacy and availability of the treatment option, the feasibility of administering parenteral medications (i.e., remdesivir), the potential for significant drug-drug interactions (e.g., those associated with the use of ritonavir-boosted nirmatrelvir [Paxlovid]), and the regional prevalence of variants of concern (e.g., the regional prevalence of the Omicron BA.2 subvariant may affect which anti-SARS-CoV-2 monoclonal antibodies [mAbs] can be used for treatment).

Table 2a outlines the COVID-19 Treatment Guidelines Panel’s (the Panel) recommendations for using these therapeutic interventions outside the hospital inpatient setting.

### Table 2a. Therapeutic Management of Nonhospitalized Adults With COVID-19

<table>
<thead>
<tr>
<th>Patient Disposition</th>
<th>Panel’s Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does Not Require Hospitalization or Supplemental Oxygen</strong></td>
<td></td>
</tr>
<tr>
<td>For All Patients:</td>
<td></td>
</tr>
<tr>
<td>- All patients should be offered symptomatic management (AIII).</td>
<td></td>
</tr>
<tr>
<td>- The Panel recommends against the use of dexamethasone or other systemic corticosteroids in the absence of another indication (AIIb).</td>
<td></td>
</tr>
<tr>
<td>For Patients Who Are at High Risk of Progressing to Severe COVID-19</td>
<td></td>
</tr>
<tr>
<td>Preferred therapies. Listed in order of preference:</td>
<td></td>
</tr>
<tr>
<td>- Ritonavir-boosted nirmatrelvir (Paxlovid)(^c,d) (AIIa)</td>
<td></td>
</tr>
<tr>
<td>- Remdesivir(^d,e) (BIIa)</td>
<td></td>
</tr>
<tr>
<td>Alternative therapies. For use ONLY when neither of the preferred therapies are available, feasible to use, or clinically appropriate. Listed in alphabetical order:</td>
<td></td>
</tr>
<tr>
<td>- Bebtelovimab(^f) (CIII)</td>
<td></td>
</tr>
<tr>
<td>- Molnupiravir(^d,g) (CIIa)</td>
<td></td>
</tr>
<tr>
<td><strong>Discharged From Hospital Inpatient Setting in Stable Condition and Does Not Require Supplemental Oxygen</strong></td>
<td></td>
</tr>
<tr>
<td>The Panel recommends against continuing the use of remdesivir (Alla), dexamethasone(^e) (Alla), or baricitinib (Alla) after hospital discharge.</td>
<td></td>
</tr>
<tr>
<td><strong>Discharged From Hospital Inpatient Setting and Requires Supplemental Oxygen</strong></td>
<td></td>
</tr>
<tr>
<td>For those who are stable enough for discharge but still require oxygen(^h)</td>
<td></td>
</tr>
<tr>
<td>There is insufficient evidence to recommend either for or against the continued use of remdesivir or dexamethasone.</td>
<td></td>
</tr>
<tr>
<td><strong>Discharged From ED Despite New or Increasing Need for Supplemental Oxygen</strong></td>
<td></td>
</tr>
<tr>
<td>When hospital resources are limited, inpatient admission is not possible, and close follow-up is ensured(^i)</td>
<td></td>
</tr>
<tr>
<td>The Panel recommends using dexamethasone 6 mg PO once daily for the duration of supplemental oxygen (dexamethasone use <strong>should not exceed</strong> 10 days) with careful monitoring for AEs (BII).</td>
<td></td>
</tr>
<tr>
<td>Because remdesivir is recommended for patients with similar oxygen needs who are hospitalized, clinicians may consider using it in this setting. As remdesivir requires IV infusions for up to 5 consecutive days, there may be logistical constraints to administering remdesivir in the outpatient setting.</td>
<td></td>
</tr>
</tbody>
</table>

**Rating of Recommendations:** A = Strong; B = Moderate; C = Weak

**Rating of Evidence:** I = One or more randomized trials without major limitations; IIa = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion
There is currently a lack of safety and efficacy data on the use of dexamethasone in outpatients with COVID-19. Using systemic glucocorticoids in this setting may cause harm.

For a list of risk factors, see the CDC webpage Underlying Medical Conditions Associated With Higher Risk for Severe COVID-19.

Ritonavir-boosted nirmatrelvir has significant drug-drug interactions. Clinicians should carefully review a patient's concomitant medications and evaluate potential drug-drug interactions. See Drug-Drug Interactions Between Ritonavir-Boosted Nirmatrelvir (Paxlovid) and Concomitant Medications for more information.

If a patient requires hospitalization after starting treatment, the full treatment course can be completed at the health care provider's discretion.

Administration of remdesivir requires 3 consecutive days of IV infusion.

Bebtelovimab is active in vitro against all circulating Omicron subvariants, but there are no clinical efficacy data from placebo-controlled trials that evaluated the use of bebtelovimab in patients who are at high risk of progressing to severe COVID-19. Therefore, bebtelovimab should be used only when the preferred treatment options are not available, feasible to use, or clinically appropriate.

Molnupiravir has lower efficacy than the preferred treatment options. Therefore, it should be used only when the preferred options are not available, feasible to use, or clinically appropriate.

These individuals should receive oximetry monitoring and close follow-up through telehealth, visiting nurse services, or in-person visits.

Provide an advanced level of home care, including supplemental oxygen (whether patients are receiving oxygen for the first time or are increasing their baseline oxygen requirements), pulse oximetry, laboratory monitoring, and close follow-up through telehealth, visiting nurse services, or in-person visits.

See Therapeutic Management of Hospitalized Adults With COVID-19.

Key: AE = adverse event; CDC = Centers for Disease Control and Prevention; ED = emergency department; IV = intravenous; the Panel = the COVID-19 Treatment Guidelines Panel; PO = orally

Patient Prioritization for Treatment

When there are no logistical or supply constraints, the Panel recommends prescribing therapies for the treatment of COVID-19 for any eligible individual as recommended in these Guidelines. During surges in cases of SARS-CoV-2 infection, logistical or supply constraints may make it impossible to offer available therapeutics to all the nonhospitalized patients who are eligible to receive them. In these situations, the Panel recommends prioritizing the treatment of patients who are at the highest risk of clinical progression (see Prioritization of Anti-SARS-CoV-2 Therapies for the Treatment and Prevention of COVID-19 When There Are Logistical or Supply Constraints).

Table 2b. Dosing Regimens for the Drugs Listed in Table 2a

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Time From Symptom Onset a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ritonavir-Boosted Nirmatrelvir (Paxlovid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eGFR ≥60 mL/min:</td>
<td>- Nirmatrelvir 300 mg with RTV 100 mg PO twice daily for 5 days</td>
<td>≤5 days</td>
</tr>
<tr>
<td>eGFR 30 to &lt;60 mL/min:</td>
<td>- Nirmatrelvir 150 mg with RTV 100 mg PO twice daily for 5 days</td>
<td></td>
</tr>
<tr>
<td>eGFR &lt;30 mL/min:</td>
<td>- Not recommended</td>
<td></td>
</tr>
<tr>
<td>Severe Hepatic Impairment (Child-Pugh Class C):</td>
<td>- Not recommended</td>
<td></td>
</tr>
<tr>
<td>Remdesivir</td>
<td>RDV 200 mg IV on Day 1, followed by RDV 100 mg IV once daily on Days 2 and 3. bc Each infusion should be administered over 30–120 minutes. Patients should be observed for ≥1 hour after infusion as clinically appropriate.</td>
<td>≤7 days</td>
</tr>
</tbody>
</table>

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Symptom Management

Symptomatic treatment includes using over-the-counter antipyretics, analgesics, or antitussives for fever, headache, myalgias, and cough. Patients with dyspnea may benefit from resting in the prone position rather than the supine position. Health care providers should consider educating patients about breathing exercises, as severe breathlessness may cause anxiety. Patients should be advised to drink fluids regularly to avoid dehydration. Rest is recommended as needed during the acute phase of COVID-19, and ambulation and other forms of activity should be increased according to the patient’s tolerance. Patients should be educated about the variability in time to symptom resolution and complete recovery.

Rationale for the Use of Specific Agents Listed in Table 2a

The Panel’s recommendations for the therapeutics that are used to treat nonhospitalized patients with mild to moderate COVID-19 who are at risk of clinical progression are based on the results of clinical trials for the antiviral drugs (ritonavir-boosted nirmatrelvir, remdesivir, and molnupiravir) and on laboratory assessments of the activity of the anti-SARS-CoV-2 mAb bebtelovimab.

Several factors affect the selection of the best treatment option for a specific patient. These factors include the clinical efficacy of the treatment option against circulating variants, the availability of the treatment option, the feasibility of administering parenteral medications (i.e., remdesivir, bebtelovimab), and the potential for significant drug-drug interactions (i.e., the interactions associated with using ritonavir-boosted nirmatrelvir).

The Panel recommends ritonavir-boosted nirmatrelvir and remdesivir as preferred therapy options because Phase 3 randomized placebo-controlled trials have reported high clinical efficacies for these agents in patients with COVID-19. The Panel favors the use of ritonavir-boosted nirmatrelvir in most high-risk, nonhospitalized patients with mild to moderate COVID-19. If ritonavir-boosted nirmatrelvir is not available or cannot be used because of drug-drug interactions, the Panel recommends using remdesivir as the second option.

The Panel recommends bebtelovimab and molnupiravir as alternative therapy options. These drugs should ONLY be used when neither of the preferred treatment options are available, feasible to use, or clinically appropriate. The Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for bebtelovimab based on in vitro data that showed that bebtelovimab has activity against all circulating Omicron subvariants and clinical efficacy data from a small, Phase 2 clinical trial in individuals with mild to moderate COVID-19 who were at low risk of disease progression. However, there are no Phase 3 clinical trial data for bebtelovimab. Molnupiravir had lower clinical efficacy in...
Phase 3 clinical trials than the preferred treatment options. The Panel previously recommended the anti-SARS-CoV-2 mAb sotrovimab as a treatment option for certain nonhospitalized patients with COVID-19. However, sotrovimab, which is active against the Omicron BA.1 and BA.1.1 subvariants, has substantially decreased in vitro activity against the Omicron BA.2 subvariant. The distribution of sotrovimab has been paused, and the Panel no longer recommends using sotrovimab to treat COVID-19.

There are currently no clinical trial data that directly compare the clinical efficacies of the 4 recommended therapies, and there are no data on the use of combinations of antiviral agents and/or anti-SARS-CoV-2 mAbs for the treatment of COVID-19. The rationale for each of the Panel’s recommendations is discussed below.

**Ritonavir-Boosted Nirmatrelvir (Paxlovid)**

Nirmatrelvir is an orally bioavailable protease inhibitor that is active against M<sub>PRO</sub>, a viral protease that plays an essential role in viral replication by cleaving the 2 viral polyproteins. It has demonstrated antiviral activity against all coronaviruses that are known to infect humans. Nirmatrelvir is packaged with ritonavir (as Paxlovid), a strong cytochrome P450 (CYP) 3A4 inhibitor and pharmacokinetic boosting agent. Ritonavir is required to increase nirmatrelvir concentrations to the target therapeutic range.

**Recommendations**

- The Panel recommends using **nirmatrelvir 300 mg with ritonavir 100 mg (Paxlovid)** orally (PO) twice daily for 5 days in those aged ≥12 years and weighing ≥40 kg; treatment should be initiated as soon as possible and within 5 days of symptom onset (AIIa).
- Ritonavir-boosted nirmatrelvir has significant and complex drug-drug interactions, primarily due to the ritonavir component of the combination.
- Before prescribing ritonavir-boosted nirmatrelvir, clinicians should carefully review the patient’s concomitant medications, including over-the-counter medications and herbal supplements, to evaluate potential drug-drug interactions.
- A quick reference guide is also provided in [Drug-Drug Interactions Between Ritonavir-Boosted Nirmatrelvir (Paxlovid) and Concomitant Medications](https://www.covid19treatmentguidelines.nih.gov/).

In the EPIC-HR trial, ritonavir-boosted nirmatrelvir reduced the risk of hospitalization or death by 88% compared to placebo in nonhospitalized adults with laboratory-confirmed SARS-CoV-2 infection. This efficacy is comparable to the efficacies reported in similar patient populations for remdesivir (87% relative reduction) and greater than the efficacy reported for molnupiravir in this setting (30% relative reduction).

Ritonavir-boosted nirmatrelvir is expected to be active against all Omicron subvariants, although clinical efficacy data are lacking. Because ritonavir-boosted nirmatrelvir has the potential for significant drug-drug interactions with concomitant medications, this regimen may not be a safe choice for all patients (see [Drug-Drug Interactions Between Ritonavir-Boosted Nirmatrelvir (Paxlovid) and Concomitant Medications](https://www.covid19treatmentguidelines.nih.gov/)). However, because ritonavir-boosted nirmatrelvir is the only highly effective oral antiviral available for the treatment of COVID-19, drug-drug interactions that can be safely managed should not preclude the use of this medication.

Case reports and results from the EPIC-HR trial have described SARS-CoV-2 viral rebound and the recurrence of COVID-19 symptoms in some patients who have completed treatment with ritonavir-boosted nirmatrelvir. Viral and symptomatic rebound can also occur in the absence of treatment with...
ritonavir-boosted nirmatrelvir. The frequency, mechanism, and clinical implications of these events are unclear. To date, recurrence of symptoms following the use of ritonavir-boosted nirmatrelvir has not been associated with progression to severe COVID-19. Longer treatment courses of ritonavir-boosted nirmatrelvir are not authorized based on the current EUA, and there are insufficient data on the efficacy of administering a second course.

The EPIC-HR trial excluded pregnant and lactating individuals. Ritonavir has been used extensively during pregnancy in people with HIV, which suggests that it has an acceptable safety profile during pregnancy. Based on the mechanisms of action for both nirmatrelvir and ritonavir and the available animal data, the Panel recommends ritonavir-boosted nirmatrelvir for pregnant patients because the potential benefits likely outweigh the risks.

Remdesivir

Remdesivir is currently approved by the FDA for use in hospitalized patients with COVID-19 and in nonhospitalized patients with mild to moderate COVID-19 who are at high risk of disease progression. Remdesivir has been studied in nonhospitalized patients with mild to moderate COVID-19 who were at high risk of progressing to severe disease. The PINETREE trial showed that 3 consecutive days of intravenous (IV) remdesivir resulted in an 87% relative reduction in the risk of hospitalization or death compared to placebo. Remdesivir is expected to be active against the Omicron variant, although in vitro and in vivo data are currently limited. See Remdesivir for more information.

Recommendations

- The Panel recommends using remdesivir 200 mg IV on Day 1, followed by remdesivir 100 mg IV once daily on Days 2 and 3 in those aged ≥12 years and weighing ≥40 kg; treatment should be initiated as soon as possible and within 7 days of symptom onset (BIIa).
- Remdesivir should be administered in a setting where severe hypersensitivity reactions, such as anaphylaxis, can be managed. Patients should be monitored during the infusion and observed for at least 1 hour after infusion as clinically appropriate.

Because remdesivir requires IV infusions for 3 consecutive days, there may be logistical constraints to administering remdesivir in many settings. However, it is an option if ritonavir-boosted nirmatrelvir is not available.

The Panel recommends using remdesivir, dexamethasone, or both drugs together in hospitalized patients who require supplemental oxygen (see Therapeutic Management of Hospitalized Adults With COVID-19). When remdesivir is used in this setting, it is administered as a once-daily IV infusion for 5 days. There are rare instances when hospital resources are limited and admission to an inpatient unit is not possible for patients who need to initiate supplemental oxygen in the emergency department (ED) or who have increasing supplemental oxygen requirements. In these cases, patients may be discharged from the ED with close monitoring and are often prescribed dexamethasone for up to 10 days. Since remdesivir is often recommended for hospitalized patients with COVID-19 who have similar oxygen needs, clinicians can consider using it in this setting. However, it should be noted that the data on using remdesivir in this situation are limited and administering IV infusions for up to 5 consecutive days can be difficult in the outpatient setting.

Bebtelovimab

Bebtelovimab is a recombinant neutralizing human mAb that binds to the spike protein of SARS-CoV-2. In vitro data suggest that bebtelovimab has activity against a broad range of SARS-CoV-2 variants, including the Omicron variant and its BA.1, BA.1.1, and BA.2 subvariants. However, to date, the clinical trial data for bebtelovimab come from a single Phase 2 randomized placebo-controlled trial in
patients with COVID-19 who were at low risk of progressing to severe disease. The trial showed no unexpected safety events, and patients who received bebtelovimab had more rapid viral decay than those who received the placebo.

Recommendations

- The Panel recommends using **bebtelovimab 175 mg** IV in those aged ≥12 years **ONLY** when ritonavir-boosted nirmatrelvir (Paxlovid) and remdesivir are not available, feasible to use, or clinically appropriate; treatment should be initiated as soon as possible and within 7 days of symptom onset (CIII).
- Bebtelovimab should be administered in a setting where severe hypersensitivity reactions, such as anaphylaxis, can be managed. Patients should be monitored during the infusion and observed for at least 1 hour after infusion.

Although there are insufficient data on hospitalization and mortality outcomes for patients with COVID-19 who were at high risk of disease progression and who received bebtelovimab, this agent has a mechanism of action that is similar to other anti-SARS-CoV-2 mAbs that have been shown to reduce rates of hospitalization or death among high-risk patients in Phase 3 trials. Therefore, the in vitro data and Phase 2 clinical trial data for bebtelovimab, coupled with the clinical efficacy data for other anti-SARS-CoV-2 mAbs, support the use of bebtelovimab in high-risk patients with COVID-19 when preferred treatment options are not available, feasible to use, or clinically appropriate.

**Molnupiravir**

Molnupiravir is the oral prodrug of beta-D-N4-hydroxycytidine (NHC), a ribonucleoside that has broad antiviral activity against RNA viruses. NHC uptake by viral RNA-dependent RNA-polymerases results in viral mutations and lethal mutagenesis. Molnupiravir has potent antiviral activity against SARS-CoV-2. As a mutagenic ribonucleoside antiviral agent, there is a theoretical risk that molnupiravir will be metabolized by the human host cell and incorporated into the host DNA, leading to mutations. Molnupiravir has been evaluated in 2 in vivo rodent mutagenicity assays. One study produced equivocal results; in the other study, there was no evidence for mutagenicity. The FDA concluded that, based on the available genotoxicity data and the 5-day duration of treatment, molnupiravir has a low risk for genotoxicity. In addition, there have been concerns about the potential effects of molnupiravir on SARS-CoV-2 mutation rates; the FDA is requiring the manufacturer to establish a process to monitor genomic databases for the emergence of SARS-CoV-2 variants.

Molnupiravir is expected to be active against the Omicron variant, although in vitro and in vivo data are currently limited.15

Recommendation

- The Panel recommends using **molnupiravir 800 mg** PO twice daily for 5 days in those aged ≥18 years **ONLY** when ritonavir-boosted nirmatrelvir (Paxlovid) and remdesivir are not available, feasible to use, or clinically appropriate (CIIa).

In the MOVe-OUT trial, molnupiravir reduced the rate of hospitalization or death by 30% compared to placebo in nonhospitalized patients with COVID-19.12,24 Even though the different treatment options have not been directly compared in clinical trials, the Panel recommends using molnupiravir only when ritonavir-boosted nirmatrelvir and remdesivir are not available or cannot be used, because molnupiravir has lower efficacy than the other options.

The FDA EUA states that molnupiravir is not recommended for use in pregnant patients due to concerns
about the instances of fetal toxicity observed during animal studies. However, when other therapies are not available, pregnant people with COVID-19 who are at high risk of progressing to severe disease may reasonably choose molnupiravir therapy after being fully informed of the risks, particularly if they are beyond the time of embryogenesis (i.e., >10 weeks’ gestation). The prescribing clinician should document that a discussion of the risks and benefits occurred and that the patient chose this therapy.

People who engage in sexual activity that may result in conception should use effective contraception during and following treatment with molnupiravir.

**Dexamethasone**

**For Nonhospitalized Patients With Mild to Moderate COVID-19**

The Panel recommends against the use of dexamethasone or other systemic glucocorticoids to treat outpatients with mild to moderate COVID-19 who do not require hospitalization or supplemental oxygen (AIIb). However, patients who are receiving dexamethasone or another corticosteroid for other indications should continue therapy for their underlying conditions as directed by their health care providers (AIII).

Medicare and FDA data show a significant increase in the number of prescriptions for systemic corticosteroids among nonhospitalized patients with COVID-19 despite a lack of safety and efficacy data on the use of systemic corticosteroids in this setting. Systemic glucocorticoids may cause harm in nonhospitalized patients with COVID-19. Results from 1 randomized controlled trial and 1 observational cohort study did not demonstrate a clinical benefit of dexamethasone among hospitalized patients who did not require supplemental oxygen, and dexamethasone may potentially cause harm in these patients. In the RECOVERY trial, the use of dexamethasone had no effect on mortality among hospitalized patients with COVID-19 who did not require supplemental oxygen (rate ratio 1.19; 95% CI, 0.91–1.55). A large observational study of patients at Veterans Affairs hospitals reported no survival benefit for dexamethasone among patients with COVID-19 who did not require supplemental oxygen. Instead, these patients had an increased risk of 90-day mortality (HR 1.76; 95% CI, 1.47–2.12).

However, hospitalized patients with COVID-19 are likely to have an increased risk of mortality compared to nonhospitalized patients, which is a limitation of observational trial data.

See Table 6a for more information on the clinical trials that evaluated the use of corticosteroids, including dexamethasone.

**For Patients Who Are Discharged From the Hospital and Do Not Require Supplemental Oxygen**

During the RECOVERY trial, dexamethasone was stopped at the time of hospital discharge. For hospitalized patients with COVID-19 who do not require supplemental oxygen after discharge, the Panel recommends against the continuation of dexamethasone (AIIa).

**For Patients Who Are Discharged From the Hospital and Require Supplemental Oxygen**

In some cases, adult patients are deemed to be stable enough to be discharged from the inpatient setting even though they still require supplemental oxygen. This practice was likely uncommon during the RECOVERY trial; therefore, there is insufficient evidence for the Panel to recommend either for or against the continued use of dexamethasone after hospital discharge in patients who require supplemental oxygen. The use of corticosteroids can lead to adverse events (e.g., hyperglycemia, neuropsychiatric symptoms, secondary infections), which may be difficult to detect and monitor in an outpatient setting. If a patient continues to receive corticosteroids after discharge, consider continuing corticosteroids for the duration of supplemental oxygen. However, the total duration of corticosteroid use should not exceed 10 days (including days during hospitalization). Only patients who showed good tolerance to this therapy prior to discharge should continue to receive corticosteroids after discharge.
These patients should receive oximetry monitoring and close follow-up through telehealth, visiting nurse services, or in-person visits.

**For Patients Who Require Hospitalization and Supplemental Oxygen but Were Discharged From the Emergency Department Due to Scarce Resources**

In rare cases, patients with COVID-19 who require supplemental oxygen and hospital admission may need to be discharged from the ED due to scarce resources (e.g., in cases where hospital beds or staff are not available). For these patients, the Panel recommends using **dexamethasone** 6 mg PO once daily for the duration of supplemental oxygen (dexamethasone use should not exceed 10 days) with careful monitoring for adverse events (BIII). These patients should receive oximetry monitoring and close follow-up through telehealth, visiting nurse services, or in-person visits.

**Other Agents That Have Been Studied or Are Under Investigation**

- The Panel **recommends against** the use of **chloroquine** or **hydroxychloroquine** with or without **azithromycin** (AI), **lopinavir/ritonavir**, and **other HIV protease inhibitors** (AIII) for the outpatient treatment of COVID-19.
- The Panel **recommends against** the use of **antibacterial therapy** (e.g., azithromycin, **doxycycline**) for the outpatient treatment of COVID-19 in the absence of another indication (AIII).
- Other agents have undergone or are currently undergoing investigation in the outpatient setting. For more information, please refer to the sections of the Guidelines that address:
  - **Antiviral agents**, such as ivermectin
  - **Convalescent plasma**
  - **Immunomodulators**, such as colchicine, fluvoxamine, and inhaled corticosteroids
  - **Supplements**, such as vitamin C, vitamin D, and zinc
- The Panel **recommends against** the use of **anticoagulants** and **antiplatelet therapy** for the prevention of venous thromboembolism or arterial thrombosis unless the patient has other indications for the therapy or is participating in a clinical trial (AIIa). For more information, see [Antithrombotic Therapy in Patients With COVID-19](https://www.covid19treatmentguidelines.nih.gov/).
- Health care providers should provide information about ongoing clinical trials of investigational therapies to eligible outpatients with COVID-19 so they can make informed decisions about participation (AIII).

**Concomitant Medication Management**

In general, a patient’s usual medication and/or supplement regimen should be continued after the diagnosis of COVID-19 (see [Considerations for Using Concomitant Medications in Patients With COVID-19](https://www.covid19treatmentguidelines.nih.gov/)). **Angiotensin-converting enzyme inhibitors**, **statin therapy**, **nonsteroidal anti-inflammatory drugs**, and oral, inhaled, and intranasal corticosteroids that are prescribed for comorbid conditions should be continued as directed (AIII). Patients should be advised to avoid the use of nebulized medications in the presence of others to avoid potential aerosolization of SARS-CoV-2.²⁻⁸ In patients with HIV, antiretroviral therapy should not be switched or adjusted for the purpose of preventing or treating SARS-CoV-2 infection (AIII). For more information, see [Special Considerations in People With HIV](https://www.covid19treatmentguidelines.nih.gov/).

When a patient is receiving an immunomodulating medication, the prescribing clinician should be consulted about the risks and benefits that are associated with a temporary dose reduction or discontinuation. These risks and benefits will depend on the medication’s indication and the severity of the underlying condition.
Use of Concomitant Medications With Ritonavir-Boosted Nirmatrelvir (Paxlovid)

Ritonavir-boosted nirmatrelvir has the potential for significant and complex drug-drug interactions with concomitant medications, primarily due to the ritonavir component of the combination. Boosting with ritonavir, a strong CYP3A inhibitor, is required to increase the exposure of nirmatrelvir to a concentration that is effective against SARS-CoV-2. However, ritonavir may also increase concentrations of certain concomitant medications, thereby increasing the potential for serious and sometimes life-threatening drug toxicities. Additionally, ritonavir is an inhibitor, inducer, and substrate of various other drug-metabolizing enzymes and/or drug transporters.

Before prescribing ritonavir-boosted nirmatrelvir, clinicians should carefully review the patient’s concomitant medications, including over-the-counter medicines, herbal supplements, and recreational drugs. Clinicians should refer to resources such as the Liverpool COVID-19 Drug Interactions website, Drug-Drug Interactions Between Ritonavir-Boosted Nirmatrelvir (Paxlovid) and Concomitant Medications, and the FDA EUA fact sheet for ritonavir-boosted nirmatrelvir for guidance regarding potential drug-drug interactions.

References


