Several therapeutic options are now available for the treatment of nonhospitalized adults with mild to moderate COVID-19 who are at high risk of disease progression. A number of 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).

Figure 1 outlines the COVID-19 Treatment Guidelines Panel’s (the Panel) recommendations for using these therapeutic interventions outside the hospital inpatient setting.

Figure 1. Therapeutic Management of Nonhospitalized Adults With COVID-19

![Figure 1](https://www.covid19treatmentguidelines.nih.gov/)

<table>
<thead>
<tr>
<th>PATIENT DISPOSITION</th>
<th>PANEL’S RECOMMENDATIONS</th>
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</table>
| Does Not Require Hospitalization or Supplemental Oxygen | All patients should be offered symptomatic management (AIII). For patients who are at high risk of progressing to severe COVID-19, use 1 of the following treatment options: **Preferred Therapies**  
* Listed in order of preference:  
  * Ritonavir-boosted nirmatrelvir (Paxlovid)* (Alla)  
  * Remdesivir* (BIIa)  
**Alternative Therapies**  
* For use ONLY when neither of the preferred therapies are available, feasible to use, or clinically appropriate. Listed in alphabetical order:  
  * Bebtelovimab* (CIII)  
  * Molnupiravir* (CIIa)  
The Panel recommends against the use of dexamethasone or other systemic corticosteroids in the absence of another indication (AII). |
| Discharged From Hospital Inpatient Setting in Stable Condition and Does Not Require Supplemental Oxygen | The Panel recommends against continuing the use of remdesivir (Alla), dexamethasone or baricitinib (Alla) after hospital discharge. |
| Discharged From Hospital Inpatient Setting and Requires Supplemental Oxygen  
* For those who are stable enough for discharge but who still require oxygen* | There is insufficient evidence to recommend either for or against the continued use of remdesivir or dexamethasone. |
| Discharged From ED Despite New or Increasing Need for Supplemental Oxygen  
* When hospital resources are limited, inpatient admission is not possible, and close follow-up is ensured* | 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 AEs (BIII). Since 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. |

*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*
For a list of risk factors, see the CDC webpage Underlying Medical Conditions Associated With Higher Risk for Severe COVID-19 and the Patient Prioritization for Treatment section below.

Ritonavir-boosted nirmatrelvir has significant drug-drug interactions. Clinicians should carefully review a patient’s concomitant medications and evaluate potential drug-drug interactions.

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.

There is currently a lack of safety and efficacy data on the use of this agent in outpatients with COVID-19; using systemic glucocorticoids in this setting may cause harm.

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

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).

In Table A, the Panel has prioritized the risk groups for anti-SARS-CoV-2 therapy based on 4 key elements: age, vaccination status, immune status, and the presence of risk factors for clinical progression. The groups are listed in descending order of priority. For a list of risk factors, see the Centers for Disease Control and Prevention (CDC) website Underlying Medical Conditions Associated With Higher Risk for Severe COVID-19.

Table A. Patient Risk Groups for Prioritizing the Use of Anti-SARS-CoV-2 Therapy

<table>
<thead>
<tr>
<th>Tier</th>
<th>Risk Groups</th>
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| 1    | • Immunocompromised individuals who are not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying conditions, regardless of their vaccine status (see Immunocompromising Conditions below); or  

  • Unvaccinated individuals who are at the highest risk of severe disease (anyone aged ≥75 years or anyone aged ≥65 years with additional risk factors) |

| 2    | • Unvaccinated individuals who are at risk of severe disease and who are not included in Tier 1 (anyone aged ≥65 years or anyone aged <65 years with clinical risk factors) |
Immunocompromising Conditions

The CDC website [COVID-19 Vaccines for Moderately or Severely Immunocompromised People](https://www.cdc.gov/vaccines/covid-19/moderate-severe-immuno-compromised.html) provides a list of moderate and severe immunocompromising conditions.

If these anti-SARS-CoV-2 agents cannot be provided to all moderately to severely immunocompromised individuals because of logistical constraints or supply limitations, the Panel suggests prioritizing their use for those who are least likely to mount an adequate response to COVID-19 vaccination or SARS-CoV-2 infection and who are at risk for severe outcomes. This includes:

- Patients who are within 1 year of receiving B cell-depleting therapies (e.g., rituximab, ocrelizumab, ofatumumab, alemtuzumab)
- Patients who are receiving Bruton’s tyrosine kinase inhibitors
- Chimeric antigen receptor T cell recipients
- Post-hematopoietic cell transplant recipients who have chronic graft versus host disease or who are taking immunosuppressive medications for another indication
- Patients with hematologic malignancies who are on active therapy
- Lung transplant recipients
- Patients who are within 1 year of receiving a solid organ transplant (other than a lung transplant)
- Solid organ transplant recipients with recent treatment for acute rejection with T cell- or B cell-depleting agents
- Patients with severe combined immunodeficiencies
- Patients with untreated HIV who have CD4 T lymphocyte cell counts <50 cells/mm³

If supplies are extremely limited, the Panel suggests prioritizing those who are more severely immunocompromised (based on the list above) and who have additional risk factors for severe disease.

### Table B. Dosing Regimens for the Drugs Recommended for High-Risk, Nonhospitalized Adults With Mild to Moderate COVID-19, Listed in Order of Preference Based on Efficacy and Convenience of Use

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Time From Symptom Onset&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
</table>
| Ritonavir-Boosted Nirmatrelvir (Paxlovid) | **eGFR ≥60 mL/min:**  
• Nirmatrelvir 300 mg with RTV 100 mg PO twice daily for 5 days  
**eGFR ≥30 to <60 mL/min:**  
• Nirmatrelvir 150 mg with RTV 100 mg PO twice daily for 5 days | ≤5 days |
**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.¹ Health care providers should consider educating patients about breathing exercises, as severe breathlessness may cause anxiety.² 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 Figure 1**

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.

A number of 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-19.³⁴ 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 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 that has become the dominant subvariant in the United States. Because the Omicron BA.2 subvariant is now the dominant circulating subvariant in all regions of the United States, 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 these 4 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\(^{\text{PRO}}\), 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 ranges.

#### 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.
- The EUA fact sheet for ritonavir-boosted nirmatrelvir, the Liverpool COVID-19 Drug Interactions website, and guidance from the Ontario COVID-19 Science Advisory Table should be utilized to identify and manage drug-drug interactions. A quick reference guide is also provided in the Ritonavir-Boosted Nirmatrelvir (Paxlovid) section.

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 sotrovimab (85% relative reduction) and 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.14-16 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 Ritonavir-Boosted Nirmatrelvir [Paxlovid]). However, because ritonavir-boosted nirmatrelvir is the only highly effective oral antiviral available for the treatment of COVID-19, drug interactions that can be safely managed should not preclude the use of this medication.

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.4 Remdesivir is expected to be active against the Omicron variant, although in vitro and in vivo data are currently limited.16 See the Remdesivir section for more details.

**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.7,17 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.\(^{18,19}\)

Molnupiravir has potent antiviral activity against SARS-CoV-2.\(^{19}\) 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.\(^{20}\) 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.\(^{16}\)

**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.\(^{13,20}\) 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**

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 (AIII). There is currently a lack of safety and efficacy data on the use of these agents, and systemic glucocorticoids may cause harm in these patients. 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).

In the RECOVERY trial, dexamethasone was shown to reduce mortality in hospitalized patients with COVID-19 who required supplemental oxygen. Nonhospitalized patients who did not require supplemental oxygen were not included in this trial. The Panel **recommends against** the use of dexamethasone or other systemic glucocorticoids in this population, as there are no clinical trial data to support their use (AIII).

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

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

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 for Use in Outpatients With COVID-19**

- 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

- 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 and nitazoxanide
  - **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.

- 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). 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. 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.

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.

Patients who use a continuous positive airway pressure (CPAP) device or a bilevel positive airway pressure (BiPAP) device to manage obstructive sleep apnea may continue to use their machine. As with nebulizers, patients should be advised to use the device only when they are isolated from others.

**Use of Concomitant Medications With Ritonavir-Boosted Nirmatrelvir (Paxlovid)**

Ritonavir-boosted nirmatrelvir is one of the preferred agents for the treatment of mild to moderate COVID-19 in nonhospitalized patients who are at risk of clinical progression. It 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, the Ritonavir-Boosted Nirmatrelvir (Paxlovid) section, and the EUA fact sheet for ritonavir-boosted nirmatrelvir for guidance regarding potential drug-drug interactions.

References


14. Greasley SE, Noell S, Plotnikova O, et al. Structural basis for nirmatrelvir in vitro efficacy against the


