

# Antiviral Drugs That Are Approved or Under Evaluation for the Treatment of COVID-19

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Summary Recommendations
<p><b>Remdesivir is the only Food and Drug Administration-approved drug for the treatment of COVID-19.</b> In this section, the COVID-19 Treatment Guidelines Panel (the Panel) provides recommendations for using antiviral drugs to treat COVID-19 based on the available data. <b>As in the management of any disease, treatment decisions ultimately reside with the patient and their health care provider.</b> For more information on these antiviral agents, see <a href="#">Table 2</a>.</p>
<p><b>Remdesivir</b></p> <ul style="list-style-type: none"><li>• See <a href="#">Therapeutic Management of Patients with COVID-19</a> for recommendations on using remdesivir with or without dexamethasone.</li></ul>
<p><b>Chloroquine or Hydroxychloroquine With or Without Azithromycin</b></p> <ul style="list-style-type: none"><li>• The Panel <b>recommends against</b> the use of <b>chloroquine</b> or <b>hydroxychloroquine</b> with or without azithromycin for the treatment of COVID-19 in hospitalized patients <b>(AI)</b>.</li><li>• In nonhospitalized patients, the Panel <b>recommends against</b> the use of <b>chloroquine</b> or <b>hydroxychloroquine</b> with or without <b>azithromycin</b> for the treatment of COVID-19, except in a clinical trial <b>(AI)</b>.</li><li>• The Panel <b>recommends against</b> the use of <b>high-dose chloroquine</b> (600 mg twice daily for 10 days) for the treatment of COVID-19 <b>(AI)</b>.</li></ul>
<p><b>Lopinavir/Ritonavir and Other HIV Protease Inhibitors</b></p> <ul style="list-style-type: none"><li>• The Panel <b>recommends against</b> using <b>lopinavir/ritonavir (AI)</b> or <b>other HIV protease inhibitors (AIII)</b> to treat COVID-19, except in a clinical trial.</li></ul>
<p><b>Ivermectin</b></p> <ul style="list-style-type: none"><li>• The Panel <b>recommends against</b> the use of <b>ivermectin</b> for the treatment of COVID-19, except in a clinical trial <b>(AIII)</b>.</li></ul>
<p><b>Rating of Recommendations:</b> A = Strong; B = Moderate; C = Optional</p> <p><b>Rating of Evidence:</b> I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies; III = Expert opinion</p>

## Antiviral Therapy

Because severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) replication leads to many of the clinical manifestations of COVID-19, antiviral therapies are being investigated for the treatment of COVID-19. These drugs inhibit viral entry (via the angiotensin-converting enzyme 2 [ACE2] receptor and transmembrane serine protease 2 [TMPRSS2]), viral membrane fusion and endocytosis, or the activity of the SARS-CoV-2 3-chymotrypsin-like protease (3CLpro) and the RNA-dependent RNA polymerase.<sup>1</sup> Because viral replication may be particularly active early in the course of COVID-19, antiviral therapy may have the greatest impact before the illness progresses into the hyperinflammatory state that can characterize the later stages of disease, including critical illness.<sup>2</sup> For this reason, it is necessary to understand the role of antivirals in treating mild, moderate, severe, and critical illness in order to optimize treatment for people with COVID-19.

The following sections describe the underlying rationale for using different antiviral medications, provide the Panel's recommendations for using these medications to treat COVID-19, and summarize the existing clinical trial data. Additional antiviral therapies will be added to this section of the Guidelines as new evidence emerges.

## References

1. Sanders JM, Monogue ML, Jodlowski TZ, Cutrell JB. Pharmacologic treatments for coronavirus disease 2019 (COVID-19): a review. *JAMA*. 2020. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32282022>.
2. Siddiqi HK, Mehra MR. COVID-19 illness in native and immunosuppressed states: A clinical-therapeutic staging proposal. *J Heart Lung Transplant*. 2020;39(5):405-407. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32362390>.

# Remdesivir

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Remdesivir is an intravenous nucleotide prodrug of an adenosine analog. Remdesivir binds to the viral RNA-dependent RNA polymerase, inhibiting viral replication through premature termination of RNA transcription. It has demonstrated in vitro activity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).<sup>1</sup> In a rhesus macaque model of SARS-CoV-2 infection, remdesivir treatment was initiated soon after inoculation; the remdesivir-treated animals had lower virus levels in the lungs and less lung damage than the control animals.<sup>2</sup>

Remdesivir is approved by the Food and Drug Administration (FDA) for the treatment of COVID-19 in hospitalized adult and pediatric patients (aged  $\geq 12$  years and weighing  $\geq 40$  kg). It is also available through an FDA Emergency Use Authorization (EUA) for the treatment of COVID-19 in hospitalized pediatric patients weighing 3.5 kg to  $< 40$  kg or aged  $< 12$  years and weighing  $\geq 3.5$  kg. Remdesivir should be administered in a hospital or a health care setting that can provide a similar level of care to an inpatient hospital.

Remdesivir has been studied in several clinical trials for the treatment of COVID-19. The recommendations from the COVID-19 Treatment Guidelines Panel (the Panel) are based on the results of these studies. See [Remdesivir: Selected Clinical Data](#) for more information.

The safety and efficacy of combination therapy of remdesivir with corticosteroids have not been rigorously studied in clinical trials; however, there are theoretical reasons that the combination therapy may be beneficial in some patients with severe COVID-19. For the Panel's recommendations on using remdesivir with or without dexamethasone in certain hospitalized patients, see [Therapeutic Management of Patients with COVID-19](#).

## Monitoring, Adverse Effects, and Drug-Drug Interactions

Remdesivir can cause gastrointestinal symptoms (e.g., nausea), elevated transaminase levels, an increase in prothrombin time, and hypersensitivity reactions.

Liver function tests and prothrombin time should be obtained in all patients before remdesivir is administered and during treatment as clinically indicated. Remdesivir may need to be discontinued if alanine transaminase (ALT) levels increase to  $> 10$  times the upper limit of normal and should be discontinued if an increase in ALT level and signs or symptoms of liver inflammation are observed.<sup>3</sup>

Because the remdesivir formulation contains renally cleared sulfobutylether-beta-cyclodextrin sodium, patients with an estimated glomerular filtration rate (eGFR) of  $< 50$  mL/minute were excluded from some clinical trials; other trials had an eGFR cutoff of  $< 30$  mL/minute. Remdesivir **is not recommended** for patients with eGFR  $< 30$  mL/minute. Renal function should be monitored in patients before and during remdesivir treatment as clinically indicated.<sup>3</sup>

Clinical drug-drug interaction studies of remdesivir have not been conducted. In vitro, remdesivir is a substrate of cytochrome P450 (CYP) 3A4 and of the drug transporters organic anion-transporting polypeptide (OATP) 1B1 and P-glycoprotein. It is also an inhibitor of CYP3A4, OATP1B1, OATP1B3, and MATE1.<sup>3</sup>

Minimal to no reduction in remdesivir exposure is expected when remdesivir is coadministered with dexamethasone, according to information provided by Gilead Sciences (written communication, July 2020). Chloroquine or hydroxychloroquine may decrease the antiviral activity of remdesivir;

coadministration of these drugs **is not recommended**.<sup>3</sup> Remdesivir is not expected to have any significant interactions with oseltamivir or baloxavir, according to information provided by Gilead Sciences (written communications, August and September 2020).

See [Table 2: Characteristics of Antiviral Agents That Are Approved or Under Evaluation for Treatment of COVID-19](#) for more information.

## Considerations in Pregnancy

- Pregnant patients were excluded from the clinical trials that evaluated the safety and efficacy of remdesivir for the treatment of COVID-19, but preliminary reports of use in pregnant patients through the remdesivir compassionate use program are reassuring.
- Among 86 pregnant and postpartum hospitalized patients with severe COVID-19 who received compassionate use remdesivir, the therapy was well tolerated, with a low rate of serious adverse events.<sup>4</sup>
- Remdesivir should not be withheld from pregnant patients if it is otherwise indicated.

## Considerations in Children

- The safety and effectiveness of remdesivir for the treatment of COVID-19 have not been evaluated in pediatric patients aged <12 years or weighing <40 kg.
- Remdesivir is available through an FDA EUA for the treatment of COVID-19 in hospitalized pediatric patients weighing 3.5 kg to <40 kg or aged <12 years and weighing  $\geq 3.5$  kg.
- A clinical trial is currently evaluating the pharmacokinetics of remdesivir in children (*ClinicalTrials.gov* identifier [NCT04431453](#)).

## Clinical Trials

Several clinical trials that are evaluating remdesivir for the treatment of COVID-19 are currently underway or in development. Please see [ClinicalTrials.gov](#) for the latest information.

## References

1. Wang M, Cao R, Zhang L, et al. Remdesivir and chloroquine effectively inhibit the recently emerged novel coronavirus (2019-nCoV) in vitro. *Cell Res*. 2020;30(3):269-271. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32020029>.
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4. Burwick RM, Yawetz S, Stephenson KE, et al. Compassionate use of remdesivir in pregnant women with severe Covid-19. *Clin Infect Dis*. 2020. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/33031500>.

# Remdesivir: Selected Clinical Data

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Remdesivir is approved by the Food and Drug Administration for the treatment of COVID-19 in hospitalized adult and pediatric patients (aged  $\geq 12$  years and weighing  $\geq 40$  kg).<sup>1</sup>

The information presented in this section may include data from preprints or articles that have not been peer reviewed. This section will be updated as new information becomes available. Please see [ClinicalTrials.gov](https://clinicaltrials.gov) for more information on clinical trials that are evaluating remdesivir.

## Multinational Randomized Controlled Trial of Remdesivir Versus Placebo in Hospitalized Patients

The Adaptive COVID-19 Treatment Trial (ACTT-1) is a National Institutes of Health-sponsored, multinational, randomized, double-blind, placebo-controlled trial.<sup>2</sup> Patients received either placebo for 10 days or intravenous (IV) remdesivir at a dose of 200 mg on Day 1 and then 100 mg daily for up to 9 more days. The primary study endpoint was time to clinical recovery. Severity of illness at baseline and at Day 15 was assessed using an eight-point ordinal scale:

1. Not hospitalized, no limitations
2. Not hospitalized, with limitations
3. Hospitalized, no active medical problems
4. Hospitalized, not on oxygen
5. Hospitalized, on oxygen
6. Hospitalized, on high-flow oxygen or noninvasive mechanical ventilation
7. Hospitalized, on mechanical ventilation or extracorporeal membrane oxygenation (ECMO)
8. Death

### ***Study Population***

The study population consisted of hospitalized patients aged  $\geq 18$  years with laboratory-confirmed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. Patients were enrolled if they met at least one of the following conditions:

- The patient had pulmonary infiltrates, as determined by radiographic imaging;
- SpO<sub>2</sub> was  $\leq 94\%$  on room air;
- The patient required supplemental oxygen;
- The patient was on mechanical ventilation; *or*
- The patient was on ECMO.

The study excluded individuals who had alanine transaminase (ALT) or aspartate transaminase (AST) levels  $>5$  times the upper limit of normal (ULN), those who had an estimated glomerular filtration rate  $<30$  mL/minute, and those who were pregnant or breastfeeding.

### ***Results***

- 1,062 participants were enrolled.
- The median time from symptom onset to randomization was 9 days (IQR 6–12 days).

- Remdesivir significantly reduced the time to recovery compared to placebo (median time to recovery was 10 days vs. 15 days; recovery rate ratio 1.29; 95% CI, 1.12–1.49;  $P < 0.001$ ).
- Clinical improvement based on the ordinal scale outlined above was significantly higher at Day 15 in patients who received remdesivir than in those who received placebo (OR 1.5; 95% CI, 1.2–1.9,  $P < 0.001$ ).
- The benefit of remdesivir for reducing time to recovery was clearest in the subgroup of hospitalized patients who required supplemental oxygenation at study enrollment (ordinal scale 5,  $n = 435$ ; recovery rate ratio 1.45; 95% CI, 1.18–1.79). In a post hoc analysis of deaths by Day 15, remdesivir appeared to confer a survival benefit in this subgroup (HR for death 0.28; 95% CI, 0.12–0.66).
- In patients who required high-flow oxygen or noninvasive ventilation at study enrollment (ordinal scale 6,  $n = 193$ ), there was no observed difference in time to recovery between the remdesivir and placebo groups (recovery rate ratio 1.09, 95% CI, 0.76–1.57). In a post hoc analysis of deaths by Day 15, there was no evidence that remdesivir had an impact on the mortality rate in this subgroup (HR 0.82; 95% CI, 0.40–1.69).
- Among the patients who were on mechanical ventilation or ECMO at study enrollment (ordinal scale 7,  $n = 285$ ), there was no observed difference in time to recovery between the remdesivir and placebo groups (recovery rate ratio 0.98; 95% CI, 0.70–1.36). In a post hoc analysis of deaths by Day 15, there was no evidence that remdesivir had an impact on the mortality rate in this subgroup (HR 0.76; 95% CI, 0.39–1.50).
- Among patients who were classified as having mild to moderate disease at enrollment, there was no difference in the median time to recovery between the remdesivir and placebo groups. Mild to moderate disease was defined as  $SpO_2 > 94\%$  on room air and a respiratory rate of  $< 24$  breaths/minute without supplemental oxygen.
- There was no statistically significant difference in mortality by Day 29 between the remdesivir (11.4%) and placebo (15.2%) arms (HR 0.73; 95% CI, 0.52–1.03;  $P = 0.07$ ).
- Mortality rates by Day 29 differed between groups according to baseline severity, with the greatest difference observed in ordinal scale 5 (HR 0.30; 95% CI, 0.14–0.64), compared to ordinal scale 6 (HR 1.02; 95% CI, 0.54–1.91) and ordinal scale 7 (HR 1.13; 95% CI, 0.67–1.89).
- The benefit of remdesivir was greater in participants who were randomized during the first 10 days after symptom onset.
- The percentages of participants with serious adverse effects (AEs) were similar in the remdesivir and placebo groups (25% vs. 32%).
- Transaminase elevations occurred in 6% of remdesivir recipients and 10.7% of placebo recipients.

### ***Limitations***

- The study was conducted in patients with a wide range of disease severity. The study was not powered to detect differences within subgroups.
- The study was powered to detect differences in clinical improvement, not mortality.
- No data were collected on longer-term morbidity.

### ***Interpretation***

In patients with severe COVID-19, remdesivir reduced the time to clinical recovery. The benefit of remdesivir was most apparent in hospitalized patients who only required supplemental oxygen. There was no observed benefit of remdesivir in those who were on high-flow oxygen, noninvasive ventilation,

mechanical ventilation, or ECMO, but the study was not powered to detect differences within subgroups. There was no observed benefit of remdesivir in patients with mild or moderate COVID-19, but the number of participants in these categories was relatively small.

## Randomized Controlled Trial of Remdesivir Versus Placebo for Severe COVID-19 in China

This was a multicenter, double-blind, randomized, placebo-controlled trial that evaluated patients with severe COVID-19 in China. Patients were randomized 2:1 to receive IV remdesivir (200 mg on Day 1, followed by 100 mg daily) or normal saline placebo for 10 days. The primary study endpoint was time to clinical improvement, defined as improvement on an ordinal scale or discharged alive from the hospital, whichever came first. The planned sample size was 453 patients.<sup>3</sup>

### *Study Population*

This study enrolled hospitalized adults with laboratory-confirmed SARS-CoV-2 infection whose time from symptom onset to randomization was <12 days. These patients had SpO<sub>2</sub> ≤94% on room air or PaO<sub>2</sub>/FiO<sub>2</sub> <300 mm Hg and radiographically confirmed pneumonia.

### *Results*

- In this study, 237 patients were randomized to receive remdesivir (n = 158) or placebo (n = 79). The study was stopped before target enrollment was reached due to control of the COVID-19 outbreak in China.
- The median time from symptom onset to randomization was 9 days for the remdesivir group and 10 days for the placebo group.
- Sixty-five percent of the participants in the remdesivir group and 68% of the participants in the placebo group received corticosteroids.
- Twenty-eight percent of the participants in the remdesivir group and 29% of the participants in the placebo group received lopinavir/ritonavir.
- Twenty-nine percent of the participants in the remdesivir arm and 38% of the participants in the placebo arm received interferon alfa-2b.

### *Study Endpoints*

- There was no difference in the time to clinical improvement between the remdesivir and placebo groups (median time to clinical improvement was 21 days vs. 23 days; HR 1.23; 95% CI, 0.87–1.75).
- For patients who started remdesivir or placebo within 10 days of symptom onset, a faster time to clinical improvement was seen in the remdesivir arm than in the placebo arm (median of 18 days vs. 23 days; HR 1.52; 95% CI, 0.95–2.43); however, this was not statistically significant.
- The 28-day mortality was similar for the two study arms (14% of participants in the remdesivir arm vs. 13% in the placebo arm).
- There was no difference between the groups in SARS-CoV-2 viral load at baseline, and the rate of decline over time was similar between the two groups.
- The number of participants who experienced AEs was similar between the two groups (66% of participants in the remdesivir arm vs. 64% in the placebo arm).
- More participants in the remdesivir arm discontinued therapy due to AEs (12% of participants in the remdesivir arm vs. 5% in the placebo arm).

## **Limitations**

- The study was terminated early because it did not reach its target enrollment; as a result, the sample size did not have sufficient power to detect differences in clinical outcomes.
- The use of concomitant medications (i.e., corticosteroids, lopinavir/ritonavir, interferons) may have obscured the effects of remdesivir.

## **Interpretation**

There was no difference in time to clinical improvement, 28-day mortality, or rate of SARS-CoV-2 clearance between remdesivir-treated and placebo-treated patients; however, the study was underpowered to detect differences in these outcomes between the two groups.

## **Remdesivir Versus Standard Care in Hospitalized Patients with Moderate COVID-19**

This open-label, randomized trial compared the use of 10 days of remdesivir (n = 197) or 5 days of remdesivir (n = 199) to “standard care” (n = 200) in hospitalized patients.<sup>4</sup> Remdesivir was administered intravenously at a dose of 200 mg on Day 1 and then 100 mg daily.

## **Study Population**

The study enrolled patients with laboratory-confirmed SARS-CoV-2 infection and moderate pneumonia, which was defined as radiographic evidence of pulmonary infiltrates and SpO<sub>2</sub> >94% on room air at sea level.

## **Results**

- Demographic characteristics and baseline disease characteristics were similar across the three study groups.
- Patients who received 5 days of remdesivir had significantly higher odds of having a better clinical status distribution on Day 11 than those who received standard care (OR 1.65; 95% CI, 1.09–2.48; *P* = 0.02).
- The clinical status distribution on Day 11 was not significantly different between the patients who received 10 days of remdesivir and those who received standard care (*P* = 0.18).
- By Day 28, there were more hospital discharges among the patients who received remdesivir (89% in the 5-day group and 90% in the 10-day group) than among those who received standard care (83% of patients).
- Mortality was low in all groups (1% to 2%).
- Several AEs occurred more frequently among patients who were treated with remdesivir than among those who received standard care: nausea (10% of patients vs. 3% of patients), hypokalemia (6% vs. 2%), and headache (5% vs. 3%).

## **Limitations**

- The open-label design of this study may have affected decisions related to concomitant medication use and hospital discharge.
- Compared with the remdesivir groups, a greater proportion of participants in the standard care group received hydroxychloroquine, lopinavir/ritonavir, or azithromycin, which may cause AEs and which have not been shown to have a clinical benefit in hospitalized patients with COVID-19.
- The study did not collect data on the time to return to activity for patients who were discharged from the hospital.

## ***Interpretation***

Hospitalized patients with moderate COVID-19 who received 5 days of remdesivir had better outcomes than those who received standard care; however, the difference between the groups was of uncertain clinical importance.

## **Multinational, Randomized Trial of Different Durations of Remdesivir Treatment in Hospitalized Patients**

This was a manufacturer-sponsored, multinational, randomized, open-label trial in hospitalized adolescents and adults with COVID-19. Participants were randomized 1:1 to receive either 5 days or 10 days of IV remdesivir (200 mg on Day 1, followed by 100 mg daily). The primary study endpoint was clinical status at Day 14, which was assessed using a seven-point ordinal scale:<sup>5</sup>

1. Death
2. Hospitalized, on invasive mechanical ventilation or ECMO
3. Hospitalized, on noninvasive ventilation or high-flow oxygen devices
4. Hospitalized, requiring low-flow supplemental oxygen
5. Hospitalized, not requiring supplemental oxygen, but requiring ongoing medical care for COVID-19 or for other reasons
6. Hospitalized, not requiring supplemental oxygen or ongoing medical care (other than the care that was specified in the protocol for remdesivir administration)
7. Not hospitalized

## ***Study Population***

The study enrolled hospitalized patients aged  $\geq 12$  years with confirmed SARS-CoV-2 infection and radiographic evidence of pulmonary infiltrates.

Patients in this study had either  $\text{SpO}_2 \leq 94\%$  on room air or were receiving supplemental oxygen. The study excluded patients who were receiving mechanical ventilation or ECMO or who had multiorgan failure, an ALT or AST level  $>5$  times ULN, or an estimated creatinine clearance  $<50$  mL/minute.

## ***Results***

- Out of 402 randomized participants, 397 began 5 days ( $n = 200$ ) or 10 days ( $n = 197$ ) of remdesivir treatment.
- At baseline, participants in the 10-day group had worse clinical status (based on ordinal scale distribution) than those in the 5-day group ( $P = 0.02$ ).
- After adjusting for imbalances in the baseline clinical status, the Day 14 distribution in clinical status on the ordinal scale was similar in the 5-day and 10-day groups ( $P = 0.14$ ).
- The time to achieve a clinical improvement of at least two levels on the ordinal scale (median day of 50% cumulative incidence) was similar in the 5-day and 10-day groups (10 days vs. 11 days).
- The median durations of hospitalization among patients who were discharged on or before Day 14 were similar in the 5-day group (7 days; IQR 6–10 days) and 10-day group (8 days; IQR 5–10 days).
- Serious AEs were more common in the 10-day group (35%) than in the 5-day group (21%). Four percent of patients in the 5-day group and 10% of patients in the 10-day group stopped treatment because of AEs.

## ***Limitations***

- This was an open-label trial without a placebo control group, so the clinical benefit of remdesivir could not be assessed.
- There were baseline imbalances in the clinical status of participants in the 5-day and 10-day groups.

## ***Interpretation***

In hospitalized patients with severe COVID-19 who were not on mechanical ventilation or ECMO, remdesivir treatment for 5 or 10 days had similar clinical benefit.

## ***Other Reviewed Studies***

The clinical trials described in this section do not represent all of the trials that the Panel reviewed while developing the recommendations for remdesivir. The studies summarized above are those that have had the greatest impact on the Panel's recommendations.

## **References**

1. Remdesivir (VEKLURY) [package insert]. Food and Drug Administration. 2020. Available at: [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2020/214787Orig1s000lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/214787Orig1s000lbl.pdf). Accessed: October 25, 2020.
2. Beigel JH, Tomashek KM, Dodd LE, et al. Remdesivir for the treatment of COVID-19 - Final Report. *N Engl J Med*. 2020. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32445440>.
3. Wang Y, Zhang D, Du G, et al. Remdesivir in adults with severe COVID-19: a randomised, double-blind, placebo-controlled, multicentre trial. *Lancet*. 2020;395(10236):1569-1578. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32423584>.
4. Spinner CD, Gottlieb RL, Criner GJ, et al. Effect of remdesivir vs standard care on clinical status at 11 days in patients with moderate COVID-19: a randomized clinical trial. *JAMA*. 2020;324(11):1048-1057. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/32821939>.
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# Chloroquine or Hydroxychloroquine With or Without Azithromycin

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Chloroquine is an antimalarial drug that was developed in 1934. Hydroxychloroquine, an analogue of chloroquine, was developed in 1946. Hydroxychloroquine is used to treat autoimmune diseases, such as systemic lupus erythematosus (SLE) and rheumatoid arthritis, in addition to malaria. In general, hydroxychloroquine has fewer and less severe toxicities (including less propensity to prolong the QTc interval) and fewer drug-drug interactions than chloroquine.

Both chloroquine and hydroxychloroquine increase the endosomal pH, inhibiting fusion of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the host cell membranes.<sup>1</sup> Chloroquine inhibits glycosylation of the cellular angiotensin-converting enzyme 2 receptor, which may interfere with binding of severe acute respiratory syndrome-associated coronavirus (SARS-CoV) to the cell receptor.<sup>2</sup> In vitro studies have suggested that both chloroquine and hydroxychloroquine may block the transport of SARS-CoV-2 from early endosomes to endolysosomes, possibly preventing the release of the viral genome.<sup>3</sup> Both chloroquine and hydroxychloroquine also have immunomodulatory effects. It has been hypothesized that these effects are other potential mechanisms of action for the treatment of COVID-19. However, despite demonstrating antiviral activity in some in vitro systems, hydroxychloroquine with or without azithromycin did not reduce upper or lower respiratory tract viral loads or demonstrate clinical efficacy in a rhesus macaque model.<sup>4</sup>

Chloroquine and hydroxychloroquine, with or without azithromycin, have been studied in multiple clinical trials for the treatment of COVID-19. The recommendations below are based on an assessment of the collective evidence from these studies.

## Recommendations

- The COVID-19 Treatment Guidelines Panel (the Panel) **recommends against** the use of **chloroquine** or **hydroxychloroquine** with or without **azithromycin** for the treatment of COVID-19 in hospitalized patients (**AI**).
- In nonhospitalized patients, the Panel **recommends against** the use of **chloroquine** or **hydroxychloroquine** with or without **azithromycin** for the treatment of COVID-19, except in a clinical trial (**AI**).
- The Panel **recommends against** the use of **high-dose chloroquine** (600 mg twice daily for 10 days) for the treatment of COVID-19 (**AI**).

## Rationale

The safety and efficacy of chloroquine and hydroxychloroquine with or without azithromycin have been evaluated in randomized clinical trials, observational studies, and single-arm studies. Please see [Chloroquine or Hydroxychloroquine With or Without Azithromycin: Selected Clinical Data](#) for more information.

In a large randomized controlled trial of hospitalized patients in the United Kingdom, hydroxychloroquine did not decrease 28-day mortality when compared to the usual standard of care. Participants who were randomized to receive hydroxychloroquine had a longer median hospital stay than those who received the standard of care. In addition, among patients who were not on invasive mechanical ventilation at the time of randomization, those who received hydroxychloroquine were

more likely to subsequently require intubation or die during hospitalization than those who received the standard of care.<sup>5</sup>

In another randomized controlled trial that was conducted in Brazil, neither hydroxychloroquine alone nor hydroxychloroquine plus azithromycin improved clinical outcomes among hospitalized patients with mild to moderate COVID-19. More adverse events occurred among patients who received hydroxychloroquine or hydroxychloroquine plus azithromycin than among those who received the standard of care.<sup>6</sup> Data from another randomized study of hospitalized patients with severe COVID-19 do not support using hydroxychloroquine plus azithromycin over hydroxychloroquine alone.<sup>7</sup>

In addition to these randomized trials, data from large retrospective observational studies do not consistently show evidence of a benefit for hydroxychloroquine with or without azithromycin in hospitalized patients with COVID-19. For example, in a large retrospective observational study of patients who were hospitalized with COVID-19, hydroxychloroquine use was not associated with a reduced risk of death or mechanical ventilation.<sup>8</sup> Another multicenter retrospective observational study evaluated the use of hydroxychloroquine with and without azithromycin in a random sample of a large cohort of hospitalized patients with COVID-19.<sup>9</sup> Patients who received hydroxychloroquine with or without azithromycin did not have a decreased risk of in-hospital mortality when compared to those who received neither hydroxychloroquine nor azithromycin.

Conversely, a large retrospective cohort study reported a survival benefit among hospitalized patients who received either hydroxychloroquine alone or hydroxychloroquine plus azithromycin, compared to those who received neither drug.<sup>10</sup> However, patients who did not receive hydroxychloroquine had a lower rate of admission to the intensive care unit, which suggests that patients in this group may have received less-aggressive care. Furthermore, a substantially higher percentage of patients in the hydroxychloroquine arms also received corticosteroids (77.1% of patients in the hydroxychloroquine arms vs. 36.5% of patients in the control arm). Given that the Randomised Evaluation of COVID-19 Therapy (RECOVERY) trial showed that corticosteroids improve the survival rate of patients with COVID-19 (see [Corticosteroids](#)), it is possible that the findings in this study were confounded by this imbalance in corticosteroid use.<sup>11</sup> These and other observational and single-arm studies are summarized in [Chloroquine or Hydroxychloroquine With or Without Azithromycin: Selected Clinical Data](#).

Many of the observational studies that have evaluated the use of chloroquine or hydroxychloroquine in patients with COVID-19 have attempted to control for confounding variables. However, study arms may be unbalanced in some of these studies, and some studies may not account for all potential confounding factors. These factors limit the ability to interpret and generalize the results from observational studies; therefore, results from these studies are not as definitive as those from large randomized trials. Given the lack of a benefit seen in the randomized clinical trials and the potential for toxicity, the Panel **recommends against** using hydroxychloroquine or chloroquine with or without azithromycin to treat COVID-19 in hospitalized patients **(AI)**.

The Panel also **recommends against** using high-dose chloroquine to treat COVID-19 **(AI)**. High-dose chloroquine (600 mg twice daily for 10 days) has been associated with more severe toxicities than lower-dose chloroquine (450 mg twice daily for 1 day, followed by 450 mg once daily for 4 days). A randomized clinical trial compared the use of high-dose chloroquine and low-dose chloroquine in hospitalized patients with severe COVID-19. In addition, all participants received azithromycin, and 89% of the participants received oseltamivir. The study was discontinued early when preliminary results showed higher rates of mortality and QTc prolongation in the high-dose chloroquine group.<sup>12</sup>

Several randomized trials have not shown a clinical benefit for hydroxychloroquine in nonhospitalized patients with COVID-19. However, other clinical trials are still ongoing.<sup>13,14</sup> In nonhospitalized

patients, the Panel **recommends against** the use of chloroquine or hydroxychloroquine with or without azithromycin for the treatment of COVID-19, except in a clinical trial (**AI**).

The combination of hydroxychloroquine and azithromycin is associated with QTc prolongation in patients with COVID-19. Given the long half-lives of both azithromycin (up to 72 hours) and hydroxychloroquine (up to 40 days), caution is warranted even when the two drugs are used sequentially instead of concomitantly.<sup>15</sup>

Please see [Chloroquine or Hydroxychloroquine With or Without Azithromycin: Selected Clinical Data](#) for additional details.

## Adverse Effects

Chloroquine and hydroxychloroquine have a similar toxicity profile, although hydroxychloroquine is better tolerated and has a lower incidence of toxicity than chloroquine.

### *Cardiac Adverse Effects*

- QTc prolongation, Torsade de Pointes, ventricular arrhythmia, and cardiac deaths.<sup>16</sup> If chloroquine or hydroxychloroquine is used, clinicians should monitor the patient for adverse events, especially prolonged QTc interval (**AIII**).
- The risk of QTc prolongation is greater for chloroquine than for hydroxychloroquine.
- Concomitant medications that pose a moderate to high risk for QTc prolongation (e.g., antiarrhythmics, antipsychotics, antifungals, macrolides [including azithromycin],<sup>16</sup> fluoroquinolone antibiotics)<sup>17</sup> should be used only if necessary. Consider using doxycycline rather than azithromycin as empiric therapy for atypical pneumonia.
- Multiple studies have demonstrated that concomitant use of hydroxychloroquine and azithromycin can prolong the QTc interval;<sup>18-20</sup> in an observational study, the use of hydroxychloroquine plus azithromycin was associated with increased odds of cardiac arrest.<sup>9</sup> The use of this combination warrants careful monitoring.
- Baseline and follow-up electrocardiograms are recommended when there are potential drug interactions with concomitant medications (e.g., azithromycin) or underlying cardiac diseases.<sup>21</sup>
- The risk-benefit ratio should be assessed for patients with cardiac disease, a history of ventricular arrhythmia, bradycardia (<50 bpm), or uncorrected hypokalemia and/or hypomagnesemia.

### *Other Adverse Effects*

- Hypoglycemia, rash, and nausea. Divided doses may reduce nausea.
- Retinopathy. Bone marrow suppression may occur with long-term use, but this is not likely with short-term use.

## Drug-Drug Interactions

Chloroquine and hydroxychloroquine are moderate inhibitors of cytochrome P450 (CYP) 2D6, and these drugs are also P-glycoprotein (P-gp) inhibitors. Use caution when administering these drugs with medications that are metabolized by CYP2D6 (e.g., certain antipsychotics, beta-blockers, selective serotonin reuptake inhibitors, methadone) or transported by P-gp (e.g., certain direct-acting oral anticoagulants, digoxin).<sup>22</sup> Chloroquine and hydroxychloroquine may decrease the antiviral activity of remdesivir; coadministration of these drugs **is not recommended**.<sup>23</sup>

## Considerations in Pregnancy

- Antirheumatic doses of chloroquine and hydroxychloroquine have been used safely in pregnant women with SLE.
- Hydroxychloroquine exposure has not been associated with adverse pregnancy outcomes in  $\geq 300$  human pregnancies.
- A lower dose of chloroquine (500 mg once a week) is used for malaria prophylaxis during pregnancy.
- No dose changes are necessary for chloroquine or hydroxychloroquine during pregnancy.

## Considerations in Children

- Chloroquine and hydroxychloroquine have been routinely used in pediatric populations for the treatment and prevention of malaria and for rheumatologic conditions.

## Drug Availability

- Hydroxychloroquine, chloroquine, and azithromycin **are not approved** by the Food and Drug Administration (FDA) for the treatment of COVID-19.
- Hydroxychloroquine is approved by the FDA for the treatment of malaria, lupus erythematosus, and rheumatoid arthritis. Chloroquine is approved for the treatment of malaria and extraintestinal amebiasis. Azithromycin is commonly used for the treatment and/or prevention of nontuberculous mycobacterial infection, various sexually transmitted infections, and various bacterial infections.

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# Chloroquine or Hydroxychloroquine With or Without Azithromycin: Selected Clinical Data

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Chloroquine is approved by the Food and Drug Administration (FDA) for the treatment and prevention of malaria and for the treatment of extraintestinal amebiasis. Hydroxychloroquine is approved by the FDA for the treatment of lupus erythematosus, malaria, and rheumatoid arthritis. Azithromycin is commonly used for the treatment and/or prevention of mycobacterial (nontuberculous) infection, sexually transmitted infections, and various bacterial infections. Azithromycin has primarily been studied for the treatment of COVID-19 when it is used in combination with hydroxychloroquine. The Randomised Evaluation of COVID-19 Therapy (RECOVERY) trial includes an azithromycin monotherapy arm, which is currently enrolling.

The information presented in this section may include data from preprints or articles that have not been peer reviewed. This section will be updated as new information becomes available. Please see [ClinicalTrials.gov](https://www.clinicaltrials.gov) for more information on clinical trials that are evaluating chloroquine, hydroxychloroquine, and azithromycin.

## Randomized Controlled Trials

### ***The Effect of Hydroxychloroquine in Hospitalized Patients with COVID-19: Preliminary Results from a Multicenter, Randomized Controlled Trial***

*This study has not been peer reviewed.*

RECOVERY is an ongoing, open-label, randomized controlled trial with multiple arms, including a control arm; in one arm, participants received hydroxychloroquine. The trial was conducted across 176 hospitals in the United Kingdom and enrolled hospitalized patients with clinically suspected or laboratory-confirmed severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection. Patients with prolonged QTc intervals were excluded from the hydroxychloroquine arm.

Patients were randomized in a 2:1 ratio to receive either the usual standard of care only or the usual standard of care plus hydroxychloroquine or one of the other treatments in the platform trial. Patients in the hydroxychloroquine arm received a loading dose of hydroxychloroquine 800 mg at entry and at 6 hours, followed by hydroxychloroquine 400 mg every 12 hours for the next 9 days or until discharge. The primary outcome was all-cause mortality at Day 28 after randomization.

The trial enrollment ended early on June 5, 2020, after an independent data-monitoring committee recommended reviewing the unblinded data, and the investigators and trial-steering committee concluded that the data showed no beneficial effect of hydroxychloroquine.<sup>1</sup>

### **Patient Characteristics**

- Of the 7,513 participants who were eligible for hydroxychloroquine, 1,561 were randomized to receive hydroxychloroquine and 3,155 were randomized to receive standard of care. The remaining participants were randomized to other treatment arms in the study.
- In both the hydroxychloroquine arm and the standard of care arm, the mean ages were 65 years; 41% of the participants were aged  $\geq 70$  years.
- Ninety percent of patients had laboratory-confirmed SARS-CoV-2 infection.
- Comorbidities were common; 57% of patients had at least one major comorbidity. Diabetes mellitus was present in 27% of patients, heart disease in 26%, and chronic lung disease in 22%.

- At randomization, 17% of patients were receiving invasive mechanical ventilation or extracorporeal membrane oxygenation, 60% were receiving oxygen only (with or without noninvasive ventilation), and 24% were receiving neither.
- The use of azithromycin or another macrolide during the follow-up period was similar in both arms (17% vs. 19%), as was the use of dexamethasone (8% vs. 9%).

## Results

- There was no significant difference in the primary outcome of 28-day mortality between the two arms; 418 patients (26.8%) in the hydroxychloroquine arm and 788 patients (25.0%) in the standard of care arm had died by Day 28 (rate ratio 1.09; 95% CI, 0.96–1.23;  $P = 0.18$ ).
- A similar 28-day mortality for hydroxychloroquine patients was reported during the post hoc exploratory analysis that was restricted to the 4,234 participants (90%) who had a positive SARS-CoV-2 test result.
- Participants in the hydroxychloroquine arm were less likely to survive hospitalization and had a longer median time to discharge than patients in the standard of care arm. In addition, participants who were randomized to receive hydroxychloroquine and who were not on invasive mechanical ventilation at baseline had an increased risk of requiring intubation and an increased risk of death.
- At the beginning of the study, the researchers did not record whether a patient developed a major cardiac arrhythmia after study enrollment; however, these data were later collected for 698 patients (44.7%) in the hydroxychloroquine arm and 1,357 patients (43.0%) in the standard of care arm. There were no differences between the arms in the frequency of supraventricular tachycardia, ventricular tachycardia or fibrillation, or instances of atrioventricular block that required intervention.

## Limitations

- The study was not blinded.
- Information on the occurrence of new major cardiac arrhythmia was not collected throughout the entire trial period.

## Interpretation

Hydroxychloroquine does not decrease 28-day all-cause mortality when compared to the usual standard of care in hospitalized persons with clinically suspected or laboratory-confirmed SARS-CoV-2 infection. Participants who were randomized to receive hydroxychloroquine had a longer median length of hospital stay, and those who were not on invasive mechanical ventilation at the time of randomization were more likely to require intubation or die during hospitalization if they received hydroxychloroquine.

### ***Randomized Controlled Trial of Hydroxychloroquine and Hydroxychloroquine Plus Azithromycin Among Hospitalized Patients with Mild or Moderate COVID-19 in Brazil***

This study was an open-label, three-arm, randomized controlled trial that was conducted in Brazil. The study enrolled hospitalized patients aged  $\geq 18$  years with suspected or confirmed cases of mild or moderate COVID-19 and duration of symptoms  $\leq 14$  days.

Patients received either standard of care alone, hydroxychloroquine 400 mg twice daily for 7 days (plus standard of care), or hydroxychloroquine 400 mg twice daily plus azithromycin 500 mg daily for 7 days (plus standard of care). The primary outcome was clinical status at Day 15, as assessed by a seven-point ordinal scale among the patients with confirmed COVID-19 (modified intention to treat analysis). Exclusion criteria included the need for  $>4$  L of supplemental oxygen or  $\geq 40\%$  FiO<sub>2</sub> by face mask, a history of ventricular tachycardia, or a QT interval  $\geq 480$  ms. Steroids, other immunomodulators, and

antiviral agents were allowed; 23.3% to 23.9% of patients received oseltamivir.<sup>2</sup>

### Patient Characteristics

- The analysis included 504 patients with confirmed COVID-19.
- The mean patient age was 50 years, and 58% of patients were men.
- At baseline, 58.2% of patients were ordinal level 3 (hospitalized without oxygen), and 41.8% were ordinal level 4 (hospitalized with oxygen).
- The median time from symptom onset to randomization was 7 days.

### Results

- There was no significant difference between the odds of worse clinical status at Day 15 for patients in the hydroxychloroquine group (OR 1.21; 95% CI, 0.69–2.11;  $P = 1.00$ ) and patients in the hydroxychloroquine plus azithromycin group (OR 0.99; 95% CI, 0.57–1.73;  $P = 1.00$ ).
- There were no significant differences in the secondary outcomes of the three arms, including progression to mechanical ventilation during the first 15 days and mean number of days “alive and free of respiratory support.”
- A greater proportion of patients who received hydroxychloroquine plus azithromycin (39.3%) or hydroxychloroquine alone (33.7%) experienced adverse events than those who received standard of care (22.6%).
- QT prolongation was more common in patients who received hydroxychloroquine plus azithromycin or hydroxychloroquine alone than in patients who received standard of care alone, but fewer patients in the standard of care alone group had serial electrocardiographic studies performed during the follow-up period.

### Limitations

- The study was not blinded.
- The follow-up period was restricted to 15 days.

### Interpretation

Neither hydroxychloroquine alone nor hydroxychloroquine plus azithromycin improved clinical outcomes at Day 15 after randomization among hospitalized patients with mild or moderate COVID-19.

### ***Randomized Controlled Trial of Hydroxychloroquine Versus Standard of Care for Mild or Moderate COVID-19***

This multicenter, randomized, open-label trial compared hydroxychloroquine 1,200 mg once daily for 3 days followed by hydroxychloroquine 800 mg once daily for the rest of the treatment duration (which was 2 weeks for patients with mild or moderate COVID-19 [99% of the patients] and 3 weeks for two patients with severe disease) to standard of care.<sup>3</sup>

### Results

- Each study arm enrolled 75 patients. Patients were randomized at a mean of 16.6 days after symptom onset.
- The hydroxychloroquine arm and the standard of care arm had similar negative polymerase chain reaction (PCR) conversion rates within 28 days (85.4% of participants vs. 81.3% of participants) and similar times to negative PCR conversion (median of 8 days vs. 7 days).
- There was no difference in the probability of symptom alleviation between the groups in the intention-to-treat analysis.

## Limitations

- It is unclear how the overall rate of symptom alleviation was calculated.
- The study did not reach the target sample size.

## Interpretation

This study demonstrated no difference in the rate of viral clearance between hydroxychloroquine and standard of care.

### ***High-Dose Chloroquine Versus Low-Dose Chloroquine***

A randomized, double-blind, Phase 2b study compared two different chloroquine regimens, chloroquine 600 mg twice daily for 10 days (high dose) and chloroquine 450 mg twice daily for 1 day followed by 450 mg for 4 days (low dose), in hospitalized adults with suspected cases of severe COVID-19. All patients also received ceftriaxone plus azithromycin; 89.6% of patients received oseltamivir.<sup>4</sup>

The planned study sample size was 440 participants. The study was stopped by the study's data safety monitoring board after 81 patients were enrolled.

## Results

- Forty-one patients were randomized into the high-dose arm and 40 patients were randomized into the low-dose arm.
- The overall fatality rate was 27.2%.
- Mortality by Day 13 was higher in the high-dose arm than in the low-dose arm (death occurred in 16 of 41 patients [39%] vs. in six of 40 patients [15%];  $P = 0.03$ ). This difference was no longer significant after controlling for age (OR 2.8; 95% CI, 0.9–8.5).
- Overall, QTcF >500 ms occurred more frequently in the high-dose arm (18.9% of patients) than in the low-dose arm (11.1% of patients).
- Two patients in the high-dose arm experienced ventricular tachycardia before death.

## Limitations

More older patients and more patients with a history of heart disease were randomized into the high-dose arm than into the low-dose arm.

## Interpretation

Despite the small number of patients enrolled, this study raises concerns about an increased risk of mortality when high-dose chloroquine (600 mg twice daily) is administered in combination with azithromycin and oseltamivir.

### ***Randomized Placebo-Controlled Trial of Hydroxychloroquine in Nonhospitalized Adults with Early COVID-19***

This randomized, placebo-controlled trial in the United States and Canada enrolled participants with  $\leq 4$  days of symptoms that were compatible with COVID-19 and either laboratory-confirmed SARS-CoV-2 infection or high-risk exposure within the previous 14 days. Participants were recruited through internet-based surveys. They were randomized to receive hydroxychloroquine (800 mg once, followed by 600 mg in 6–8 hours, and then 600 mg daily for 4 days) or placebo (with the same dosing frequency).

The planned primary endpoint was ordinal outcome by Day 14 in four categories: not hospitalized, hospitalized, intensive care unit (ICU) stay, or death. Due to lower than expected event rates, a new primary endpoint was defined: change in overall symptom severity over 14 days (assessed on a 10-point,

self-reported, visual analog scale). A longitudinal mixed model that was adjusted for baseline severity score was used for the analysis.<sup>5</sup>

### Patient Characteristics

- Data were collected from 423 participants (212 in the hydroxychloroquine arm and 211 in the placebo arm) for the primary end point.
- Of the 423 participants, 241 were exposed to people with COVID-19 through their position as health care workers (57%), 106 were exposed through household contacts (25%), and 76 had other types of exposure (18%).
- The median age was 40 years, and 56% of patients were women. Only 3% of patients were Black. Very few patients had comorbidities: 11% had hypertension, 4% had diabetes, and 68% had no chronic medical conditions.
- Fifty-six percent of patients were enrolled on Day 1 of symptom onset.
- In this study, 341 participants (81%) had either a positive PCR result or a high-risk exposure to a PCR-positive contact.

### Results

- Compared to the placebo recipients, hydroxychloroquine recipients had a nonsignificant 12% difference in improvement in symptoms between baseline and Day 14 (-2.60 vs. -2.33 points;  $P = 0.117$ ).
- Ongoing symptoms were reported by 24% of those on hydroxychloroquine and 30% of those in the placebo group at Day 14 ( $P = 0.21$ ).
- There was no difference in the incidence of hospitalization (four patients in the hydroxychloroquine group vs. 10 patients in the placebo group). Two of the 10 placebo participants were hospitalized for reasons that were unrelated to COVID-19.
- A higher percentage of patients who received hydroxychloroquine experienced adverse events (mostly gastrointestinal) than patients who received placebo (43% vs. 22%;  $P < 0.001$ ).

### Limitations

- This study enrolled a highly heterogeneous participant population. Only 227 of the 423 participants (53.7%) were confirmed PCR-positive for SARS-CoV-2.
- Changing the primary endpoint during the study without a new power calculation makes it difficult to assess whether the study is powered to detect differences in outcomes between the study arms.
- This study used surveys for screening, symptom assessment, and adherence reporting.
- The visual analog scale has not been commonly used, and its ability to assess acute viral respiratory infections in clinical trials has not been validated.

### Interpretation

The study has some limitations, and it did not find evidence that early administration of hydroxychloroquine reduced symptom severity in patients with mild COVID-19.

### ***Open-Label Randomized Controlled Trial of Hydroxychloroquine in Nonhospitalized Adults with Mild COVID-19***

This open-label randomized controlled trial in Spain enrolled nonhospitalized adults with laboratory-confirmed SARS-CoV-2 infection and <5 days of mild COVID-19 symptoms. Participants were mostly

health care workers. They were randomized to receive hydroxychloroquine (800 mg on Day 1, followed by 400 mg once daily for 6 days) or no antiviral treatment (control group). The primary endpoint was reduction in SARS-CoV-2 viral load, which was assessed using nasopharyngeal swabs on Days 3 and 7. Secondary endpoints were disease progression up to Day 28 and time to complete resolution of symptoms.<sup>6</sup>

### Patient Characteristics

- Of 353 participants who were randomized into the hydroxychloroquine group or the control group, 60 were excluded from the intention to treat analysis because of negative baseline reverse transcription-PCR (RT-PCR), missing RT-PCR at all follow-up visits, or consent withdrawal.
- The intention to treat analysis included 293 patients (157 in the control group and 139 in the hydroxychloroquine group). Mean age was 41.6 years, and 67% of patients were women.
- The majority of patients were healthcare workers (87%), and 53% reported chronic health conditions.
- The median time from symptom onset to enrollment was 3 days (IQR 2–4 days). The most commonly reported COVID-19 symptoms were fever, cough, and sudden olfactory loss.

### Results

- There was no significant difference in viral load reduction between the control group and hydroxychloroquine group at Day 3 (-1.41 vs. -1.41 log<sub>10</sub> copies/mL; difference of 0.01; 95% CI, -0.28 to 0.29), or at Day 7 (-3.37 vs. -3.44 log<sub>10</sub> copies/mL; difference of -0.07; 95% CI, -0.44 to 0.29).
- There was no difference in the risk of hospitalization between the two groups: 7.1% vs. 5.9% (risk ratio 0.75; 95% CI, 0.32–1.77).
- There was no difference in the median time from randomization to the resolution of COVID-19 symptoms between the two groups (12.0 days in the control arm vs. 10.0 days in the hydroxychloroquine arm; *P* = 0.38).
- A higher percentage of participants in the hydroxychloroquine arm than in the control arm experienced adverse events during the 28-day follow-up period (72% vs. 9%). The most common adverse events were gastrointestinal disorders and “nervous system disorders.”
- Serious adverse events were reported in 12 patients in the control group and in eight patients in the hydroxychloroquine group. The serious adverse events that occurred among the hydroxychloroquine patients were not deemed to be related to the drug.

### Limitations

- This was an open-label, non-placebo-controlled trial. The study design allowed for the possibility of drop-outs in the control arm and over-reporting of adverse events in the hydroxychloroquine arm.
- There was a change in the intervention during the study; the authors initially planned to include a combination of hydroxychloroquine and darunavir/cobicistat.
- The majority of the participants were relatively young health care workers.

### Interpretation

Early administration of hydroxychloroquine to patients with mild COVID-19 disease did not result in improvement in virologic clearance, a lower risk of disease progression, or a reduced time to symptom improvement.

## Observational Studies

### ***New York Department of Health Study on Hydroxychloroquine With or Without Azithromycin***

A retrospective, multicenter, observational study evaluated the use of hydroxychloroquine with and without azithromycin in a random sample of 1,438 inpatients with COVID-19. Patients were categorized into four treatment groups: hydroxychloroquine plus azithromycin, hydroxychloroquine alone, azithromycin alone, or neither drug. The primary outcome measure was in-hospital mortality, and the secondary outcome measure was cardiac arrest and arrhythmia or QT prolongation on an electrocardiogram.<sup>7</sup>

#### **Results**

- Patients in the three treatment groups had more severe disease at baseline than those who received neither drug.
- In adjusted analyses, patients who received one of the three treatment regimens did not show a decreased in-hospital mortality rate when compared with those who received neither drug.
- Patients who received hydroxychloroquine plus azithromycin had a greater risk of cardiac arrest than patients who received neither drug (OR 2.13; 95% CI, 1.12–4.05).

#### **Limitations**

Despite the large size of this study, it has the inherent limitations of an observational study. These include residual confounding from confounding variables that were unrecognized and/or unavailable for analysis.

#### **Interpretation**

Despite the limitations discussed above, these findings suggest that although hydroxychloroquine and azithromycin are not associated with an increased risk of in-hospital death, the combination of hydroxychloroquine and azithromycin may be associated with an increased risk of cardiac arrest.

### ***Observational Study of Hydroxychloroquine at a Large Medical Center in New York City***

This observational study evaluated 1,376 consecutive adults hospitalized with COVID-19. The study assessed the time from study baseline (24 hours after patients arrived at the emergency department) to intubation or death based on whether the patient received hydroxychloroquine at baseline or during follow-up. Patients who received hydroxychloroquine were prescribed a twice-daily dose of hydroxychloroquine 600 mg on the first day followed by 400 mg daily for 4 additional days; this was based on a clinical guidance protocol for the hospital.<sup>8</sup>

#### **Results**

- In this study, 811 patients (58.9%) received hydroxychloroquine and 565 (41.1%) did not.
- Hydroxychloroquine recipients were more severely ill at baseline than those who did not receive hydroxychloroquine.
- Using propensity scores to adjust for major predictors of respiratory failure and inverse probability weighting, the study demonstrated that hydroxychloroquine use was not associated with intubation or death (HR 1.04; 95% CI, 0.82–1.32).
- There was also no association between concomitant use of azithromycin and the composite endpoint of intubation or death (HR 1.03; 95% CI, 0.81–1.31).

#### **Limitations**

Despite the large size of this study, it has the inherent limitations of an observational study. These include residual confounding from confounding variables that were unrecognized and/or unavailable for analysis.

## Interpretation

The use of hydroxychloroquine for treatment of COVID-19 was not associated with harm or benefit in a large observational study.

### ***Observational Cohort of Hydroxychloroquine Versus No Hydroxychloroquine***

This retrospective observational cohort study analyzed data for adult patients who were hospitalized for severe COVID-19 pneumonia at four French tertiary care centers. The primary outcome was survival without transfer to the ICU at Day 21. An inverse probability of treatment weighting approach was used to “emulate” randomization.<sup>9</sup>

## Results

- Of the 181 patients who were eligible for the analysis, 84 participants received hydroxychloroquine within 48 hours, eight received hydroxychloroquine beyond 48 hours, and 89 did not receive hydroxychloroquine.
- In the hydroxychloroquine group, 18% of the patients received concomitant azithromycin.
- In the inverse probability of treatment-weighted analysis, there was no difference in survival rates without ICU transfer at Day 21 between the hydroxychloroquine group (76% of participants) and the non-hydroxychloroquine group (75% of participants). Similarly, there was no difference between the groups in the secondary outcomes of survival rate and survival rate without acute respiratory distress syndrome at Day 21.

## Limitations

This was a retrospective, nonrandomized study.

## Interpretation

In this retrospective study, there was no difference in the rates of clinically important outcomes between patients who received hydroxychloroquine within 48 hours of hospital admission and those who did not.

### ***Retrospective Cohort Study that Compared Hydroxychloroquine to No Hydroxychloroquine in a Health Care System in Detroit, Michigan***

A comparative, retrospective cohort study assessed the outcomes for all consecutive patients who were hospitalized for COVID-19 (which was defined as a positive SARS-CoV-2 PCR from a nasopharyngeal sample) from March 10 to May 2, 2020, in the Henry Ford Health System in Michigan.<sup>10</sup>

The primary outcome was in-hospital mortality. The study compared outcomes for patients who received hydroxychloroquine alone, hydroxychloroquine plus azithromycin, azithromycin alone, or neither drug.

An interdisciplinary task force of the health system established a COVID-19 treatment protocol that incorporated the use of hydroxychloroquine alone or in combination with azithromycin. The hydroxychloroquine dose was 400 mg twice daily for 1 day, then 200 mg twice daily for 4 days. If azithromycin was used, the dose was azithromycin 500 mg for 1 day, then 250 mg daily for 4 days. The combination of hydroxychloroquine and azithromycin was reserved for patients with severe COVID-19 and minimal cardiac risks. The clinical treatment protocol allowed for the use of tocilizumab and corticosteroids in some patients; however, the criteria for their use were not specified in the report.

## Study Population

- The analysis included 2,541 consecutive patients.
- The median patient age was 64 years (IQR 53–76 years); 51% of patients were men, 56% were African American, and 52% had a BMI  $\geq 30$ .

- The median time to follow-up was 28.5 days (IQR 3–53 days).
- The modified sequential organ failure assessment (mSOFA) score was not available for 25% of patients.
- Corticosteroids were given to 79% of patients in the hydroxychloroquine alone group, 74% of patients in the hydroxychloroquine plus azithromycin group, and 35.7% of those on neither drug.

### Mortality

- Overall, crude mortality was 18.1%. When broken down by the different groups, the mortality was 13.5% in hydroxychloroquine alone group, 20.1% in the hydroxychloroquine plus azithromycin group, 22.4% in the azithromycin alone group, and 26.4% in the group that received neither drug ( $P < 0.001$ ).
- Mortality HRs were analyzed using a multivariable Cox regression model; the group that received neither drug was used as the reference. Hydroxychloroquine alone decreased the mortality HR by 66% ( $P < 0.001$ ). Hydroxychloroquine plus azithromycin decreased the mortality HR by 71% ( $P < 0.001$ ).
- Other predictors of mortality were age  $\geq 65$  years (HR 2.6; 95% CI, 1.9–3.3); White race (HR 1.7; 95% CI, 1.4–2.1); chronic kidney disease (HR 1.7; 95% CI, 1.4–2.1); reduced O<sub>2</sub> saturation level on admission (HR 1.6; 95% CI, 1.1–2.2); and ventilator use at admission (HR 2.2; 95% CI, 1.4–3.0).
- A propensity-matched Cox regression result suggested a mortality HR of 0.487 for patients who received hydroxychloroquine (95% CI, 0.285–0.832,  $P = 0.009$ ).

### Limitations

- This retrospective observational study evaluated one health care system with an institutional protocol for hydroxychloroquine and azithromycin use.
- Because the study was not randomized and not blinded, there is a possibility of residual confounding
- There was a lower rate of ICU admission among patients who did not receive hydroxychloroquine, which suggests that this group may have received less-aggressive care.
- A substantially higher percentage of patients in the hydroxychloroquine arms also received corticosteroids compared to the control arm (77.1% vs. 35.7%). Given that the RECOVERY trial showed that dexamethasone use conferred a survival benefit (see [Corticosteroids](#)), it is possible that the findings were confounded by this imbalance in corticosteroid use.<sup>11</sup>

### Interpretation

This retrospective, propensity-matched cohort study reported a mortality benefit in hospitalized patients with COVID-19 who received either hydroxychloroquine alone or hydroxychloroquine plus azithromycin compared to receiving neither drug. However, there were substantial imbalances in corticosteroid use between the groups, which may have affected mortality. Moreover, because the study was retrospective and observational, it cannot control for other and unknown confounders.

### *Other Reviewed Studies*

The COVID-19 Treatment Guidelines Panel (the Panel) has reviewed other clinical studies of hydroxychloroquine with or without azithromycin and studies of chloroquine for the treatment of COVID-19.<sup>12-22</sup> These studies have limitations (e.g., the potential for residual confounding, small sample sizes, incomplete reporting, a lack of comparison groups) that make them less definitive and informative than large randomized clinical trials. The Panel's summaries and interpretations of some of those studies

are available in the [archived versions of the COVID-19 Treatment Guidelines](#).

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# Ivermectin

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Ivermectin is a Food and Drug Administration (FDA)-approved antiparasitic drug that is used to treat several neglected tropical diseases, including onchocerciasis, helminthiases, and scabies.<sup>1</sup> It is also being evaluated for its potential to reduce the rate of malaria transmission by killing mosquitoes that feed on treated humans and livestock.<sup>2</sup> For these indications, ivermectin has been widely used and has demonstrated an excellent safety profile.<sup>1</sup>

## Proposed Mechanism of Action and Rationale for Use in Patients With COVID-19

Ivermectin acts by inhibiting the host importin alpha/beta-1 nuclear transport proteins, which are part of a key intracellular transport process that viruses hijack to enhance infection by suppressing the host antiviral response.<sup>3</sup> Ivermectin is therefore a host-directed agent, which is likely the basis for its broad-spectrum activity *in vitro* against the viruses that cause dengue, Zika, HIV, and yellow fever.<sup>3-6</sup>

## Recommendation

- The COVID-19 Treatment Guidelines Panel **recommends against** the use of **ivermectin** for the treatment of COVID-19, except in a clinical trial (**AIII**).

## Rationale

Ivermectin has been shown to inhibit the replication of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in cell cultures.<sup>7</sup> However, pharmacokinetic and pharmacodynamic studies suggest that achieving the plasma concentrations necessary for the antiviral efficacy detected *in vitro* would require administration of doses up to 100-fold higher than those approved for use in humans.<sup>8,9</sup> Even though ivermectin appears to accumulate in the lung tissue, predicted systemic plasma and lung tissue concentrations are much lower than 2  $\mu\text{M}$ , the half-maximal inhibitory concentration ( $\text{IC}_{50}$ ) against SARS-CoV-2 *in vitro*.<sup>10,11</sup>

Ivermectin is not approved for the treatment of any viral infection, including SARS-CoV-2 infection. The FDA issued a [warning](#) in April 2020 that ivermectin intended for use in animals should not be used to treat COVID-19 in humans.

## Clinical Data in Patients With COVID-19

The available clinical data on the use of ivermectin to treat COVID-19 are limited.

## Retrospective Analysis of Using Ivermectin in Patients With COVID-19

*This study has not been peer reviewed.*

This retrospective analysis of consecutive patients with confirmed SARS-CoV-2 infection (27% with severe COVID-19) who were admitted to four Florida hospitals compared patients who received at least one dose of ivermectin (n = 173) to those who received “usual care” (n = 103). The primary outcome was all-cause, in-hospital mortality. The secondary outcomes included mortality in patients with severe disease (defined as “need for either  $\text{FiO}_2 \geq 50\%$  or noninvasive or invasive mechanical ventilation”) and extubation rates in those who were mechanically ventilated.<sup>12</sup>

## Results

- Ivermectin administration was reportedly consistent with hospital guidelines: a single dose

of 200 µg/kg, with repeat dosing on Day 7 if the patient was still hospitalized (13 patients received a second dose). Ninety percent of the ivermectin group and 97% of the usual care group received hydroxychloroquine (the majority received hydroxychloroquine in conjunction with azithromycin).

- All-cause mortality was lower among the patients in the ivermectin group than among patients in the usual care group (OR 0.27;  $P = 0.03$ ). The mortality benefit appeared to be limited to the subgroup of patients with severe disease.
- There was no difference between the groups for the median length of hospital stay (7 days in both groups) or the proportion of mechanically ventilated patients who were successfully extubated (36% in the ivermectin group vs. 15% in the usual care group;  $P = 0.07$ ).

### **Limitations**

- This was a retrospective analysis.
- The study included little or no information on oxygen saturation or radiographic findings. It was also unclear whether therapeutic interventions other than hydroxychloroquine, such as remdesivir or dexamethasone, were used in the study.
- The timing of therapeutic interventions was not standardized; if the timing is not accounted for, it can bias the survival comparison.
- The analyses of the durations of ventilation and hospitalization do not appear to account for death as a competing risk.
- No virologic assessments were performed.

### **Interpretation**

The limitations of this retrospective analysis make it difficult to draw conclusions about the efficacy of using ivermectin to treat patients with COVID-19.

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# Lopinavir/Ritonavir and Other HIV Protease Inhibitors

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Lopinavir/ritonavir and darunavir/cobicistat have been studied in patients with COVID-19.

The replication of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) depends on the cleavage of polyproteins into an RNA-dependent RNA polymerase and a helicase.<sup>1</sup> Two proteases are responsible for this cleavage: 3-chymotrypsin-like protease (3CLpro) and papain-like protease (PLpro).

Lopinavir/ritonavir is an inhibitor of severe acute respiratory syndrome-associated coronavirus (SARS-CoV) 3CLpro *in vitro*, and this protease appears to be highly conserved in SARS-CoV-2.<sup>2,3</sup> Although lopinavir/ritonavir has *in vitro* activity against SARS-CoV, it is thought to have a poor selectivity index, indicating that higher than tolerable levels of the drug might be required to achieve meaningful inhibition *in vivo*.<sup>4</sup> Lopinavir is excreted in the gastrointestinal tract; therefore, coronavirus-infected enterocytes might be exposed to higher concentrations of the drug.<sup>5</sup>

Darunavir inhibits the 3CLpro enzyme of SARS-CoV-2 and possibly also inhibits the PLpro enzyme. However, in an *in vitro* study, darunavir did not show activity against SARS-CoV-2.<sup>6</sup>

## Recommendation

- The COVID-19 Treatment Guidelines Panel **recommends against** using **lopinavir/ritonavir (AI)** or other **HIV protease inhibitors (AIII)** for the treatment of COVID-19, except in a clinical trial.

## Rationale

The pharmacodynamics of lopinavir/ritonavir raise concerns about whether it is possible to achieve drug concentrations that can inhibit the SARS-CoV-2 proteases. In addition, lopinavir/ritonavir did not show efficacy in a moderately sized randomized controlled trial in patients with COVID-19.

## Adverse Effects

The adverse effects for lopinavir/ritonavir include:

- Nausea, vomiting, diarrhea (common)
- QTc prolongation
- Hepatotoxicity

## Drug-Drug Interactions

Lopinavir/ritonavir is a potent inhibitor of cytochrome P450 3A. Coadministering lopinavir/ritonavir with medications that are metabolized by this enzyme may increase the concentrations of those medications, resulting in concentration-related toxicities. Please refer to the [Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV](#) for a list of potential drug interactions.

## Considerations in Pregnancy

- There is extensive experience with the use of lopinavir/ritonavir in pregnant women with HIV, and the drug has a good safety profile.
- There is no evidence of human teratogenicity (a 1.5-fold increase in overall birth defects can be ruled out).
- Lopinavir has low placental transfer to the fetus. Please refer to the [Recommendations for the](#)

[Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States](#) for more information.

- Lopinavir/ritonavir oral solution contains 42.4% (volume/volume) alcohol and 15.3% (weight/volume) propylene glycol and **is not recommended** for use during pregnancy. Please refer to the [Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States](#) for more information.
- The use of once-daily dosing for lopinavir/ritonavir **is not recommended** during pregnancy.

## Considerations in Children

- Lopinavir/ritonavir is approved for the treatment of HIV in infants, children, and adolescents.
- There are no data on the efficacy of using lopinavir/ritonavir to treat COVID-19 in pediatric patients.

## Clinical Data for COVID-19

- The plasma drug concentrations achieved using typical doses of lopinavir/ritonavir are far below the levels that may be needed to inhibit SARS-CoV-2 replication.<sup>7</sup>
- A moderately sized randomized trial failed to find a virologic or clinical benefit of lopinavir/ritonavir over standard of care.<sup>8</sup>
- Results from a small randomized controlled trial showed that darunavir/cobicistat was not effective for the treatment of COVID-19.<sup>9</sup>
- There are no data from clinical trials that support using other HIV protease inhibitors to treat COVID-19.
- Please see [Lopinavir/Ritonavir: Selected Clinical Data](#) for more information.

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# Lopinavir/Ritonavir: Selected Clinical Data

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*Last Updated: July 17, 2020*

The information presented in this section may include data from preprints or articles that have not been peer reviewed. This section will be updated as new information becomes available. Please see [ClinicalTrials.gov](https://www.clinicaltrials.gov) for more information on clinical trials that are evaluating lopinavir/ritonavir.

## Randomized Controlled Trial of Lopinavir/Ritonavir Versus Standard of Care

In a clinical trial that randomized 199 patients to receive lopinavir 400 mg/ritonavir 100 mg orally twice daily for 14 days or standard of care, patients who were randomized to the lopinavir/ritonavir arm did not have a shorter time to clinical improvement.<sup>1</sup>

### **Results**

- There was a lower, but not statistically significant, mortality rate for the lopinavir/ritonavir group (19.2%) than for the standard of care group (25.0%), and a shorter median intensive care unit stay for those in the lopinavir/ritonavir group than for those in the standard of care group (6 days vs. 11 days; 95% CI, -9 to 0 days).
- There was no difference in the median duration of hospital stay and the median time to clearance of viral RNA from respiratory tract samples between the two arms.
- Nausea, vomiting, and diarrhea were all more frequent among patients in the lopinavir/ritonavir-treated group.

### **Limitations**

- The study was not blinded, which may have affected the assessments of clinical improvement.
- The study was underpowered to show small effects.

### **Interpretation**

A moderately sized, randomized trial failed to find a virologic or clinical benefit of lopinavir/ritonavir over standard of care.

## Lopinavir/Ritonavir Plus Interferon Beta-1b Plus Ribavirin in Patients with COVID-19

Also see [Interferons](#) for a description of this trial and its results.

An open-label, Phase 2 clinical trial randomized 127 participants with COVID-19 2:1 to receive either a 14-day course of a combination therapy that included interferon beta-1b 8 million international units administered subcutaneously on alternating days (1–3 doses, depending on time from symptom onset) plus lopinavir 400 mg/ritonavir 100 mg orally every 12 hours and ribavirin 400 mg orally every 12 hours, or a 14-day course of lopinavir/ritonavir 400 mg/100 mg every 12 hours alone.<sup>2</sup>

In the combination therapy group, those who were admitted <7 days after symptom onset (n = 52) received triple-drug therapy; however, interferon beta-1b was not included in the regimen for those who were admitted ≥7 days after symptom onset (n = 34) because of concerns regarding its potential for inflammatory effects. The study population consisted of patients who were hospitalized in Hong Kong; the median age was 52 years and the median time from symptom onset to enrollment was 5 days. Only 12% to 14% of participants were on supplemental oxygen, and only one participant was mechanically ventilated.

## ***Results***

Patients in the combination therapy group showed faster viral clearance and more rapid clinical improvement than those in the control group.

## ***Limitations***

- Participants in both arms received lopinavir/ritonavir, so it is impossible to determine whether lopinavir/ritonavir contributed to the observed treatment effects. However, the possibility that lopinavir/ritonavir may have contributed to the effectiveness of the combination therapy also cannot be ruled out.
- The positive clinical impact of the combination therapy was limited to those who were hospitalized <7 days from symptom onset.
- Most participants in this study had mild illness, and only slightly more than 10% were on supplemental oxygen. For this reason, the study has limited applicability to hospitalized patients in the United States.

## ***Interpretation***

This study neither supports nor refutes the use of lopinavir/ritonavir with or without ribavirin in patients with COVID-19. See the [Interferons](#) section for further discussion.

## **Lopinavir/Ritonavir Versus Umifenovir Versus Standard of Care**

In a trial of 86 hospitalized patients with mild to moderate COVID-19, 34 patients were randomized to receive lopinavir/ritonavir, 35 patients received the broad-spectrum antiviral umifenovir (trade name Arbidol; not available in the United States), and 17 patients received standard of care.<sup>3</sup>

## ***Results (Comparison of Lopinavir/Ritonavir to Standard of Care)***

- The time to a negative severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) nucleic acid pharyngeal swab was similar for patients who received lopinavir/ritonavir (mean duration 9.0 days; SD  $\pm$  5.0 days) and for those who received standard of care (mean duration 9.3 days; SD  $\pm$  5.2 days).
- Progression to severe illness occurred among six patients (18%) in the lopinavir/ritonavir arm and two patients (12%) who received standard of care.
- Two patients became critically ill; both were randomized to receive lopinavir/ritonavir.

## ***Limitations***

- The trial had a small sample size.
- The study was not blinded.
- The effectiveness of umifenovir in treating COVID-19 is unknown.

## ***Interpretation***

The small sample size of this trial limits its usefulness.

## **Lopinavir/Ritonavir Pharmacokinetics in Patients With COVID-19**

In a case series, eight patients with COVID-19 were treated with lopinavir 400 mg/ritonavir 100 mg orally twice daily and had plasma trough levels of lopinavir drawn and assayed by liquid chromatography-tandem mass spectrometry.<sup>4</sup>

## Results

- The median plasma lopinavir concentration was 13.6 µg/mL.
- After correcting for protein binding, trough levels would need to be approximately 60-fold to 120-fold higher to achieve the *in vitro* half-maximal effective concentration (EC<sub>50</sub>) for SARS-CoV-2.

## Limitations

- Only the trough levels of lopinavir were quantified.
- The concentration of lopinavir required to effectively inhibit SARS-CoV-2 replication *in vivo* is currently unknown.

## Interpretation

The plasma drug concentrations that were achieved using typical doses of lopinavir/ritonavir are far below the levels that may be needed to inhibit SARS-CoV-2 replication.

## References

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## Table 2. Characteristics of Antiviral Agents That Are Approved or Under Evaluation for Treatment of COVID-19

Last Updated: November 3, 2020

- The information in this table is derived from data on the use of these drugs for FDA-approved indications or in investigational trials, and it is supplemented with data on their use in patients with COVID-19, when available.
- There are limited or no data on dose modifications for patients with organ failure or those who require extracorporeal devices. Please refer to product labels, when available.
- There are currently not enough data to determine whether certain medications can be safely coadministered with therapies for the treatment of COVID-19. When using concomitant medications with similar toxicity profiles, consider performing additional safety monitoring.
- The potential additive, antagonistic, or synergistic effects and the safety of using combination therapies for the treatment of COVID-19 are unknown. Clinicians are encouraged to report AEs to the [FDA MedWatch program](#).
- For drug interaction information, please refer to product labels and visit [the Liverpool COVID-19 Drug Interactions website](#).
- For information on drugs that prolong the QTc interval, please visit [CredibleMeds.org](#).

Drug Name	Dosing Regimens <i>The doses listed here are for approved indications or from reported experiences or clinical trials.</i>	Adverse Effects	Monitoring Parameters	Drug-Drug Interaction Potential	Panel's Recommendations, Comments, and Links to Clinical Trials
Chloroquine	<p><b>Dose Previously Suggested in an EUA for Adults and Adolescents Weighing ≥50 kg:</b></p> <ul style="list-style-type: none"> <li>• CQ 1 g PO once on Day 1, then CQ 500 mg PO once daily for 4–7 days of total treatment. Treatment duration should be based on clinical evaluation.</li> </ul>	<ul style="list-style-type: none"> <li>• Prolonged QTc interval, Torsades de Pointes, AV block, ventricular arrhythmia</li> <li>• Gastrointestinal effects (e.g., nausea, vomiting, diarrhea)</li> <li>• Hepatitis</li> <li>• Hypoglycemia</li> <li>• Hemolysis (especially in patients with G6PD deficiency)</li> <li>• Myopathy</li> <li>• Rash</li> </ul>	<ul style="list-style-type: none"> <li>• CBC, hepatic panel, blood glucose, SCr, potassium, magnesium</li> <li>• Baseline ECG</li> <li>• Follow-up ECG if CQ is given with QTc-prolonging drugs or if the patient has underlying cardiac disease</li> </ul>	<ul style="list-style-type: none"> <li>• Additive effect with other drugs that prolong the QTc interval (including AZM) or that cause hypoglycemia</li> <li>• CYP2D6 inhibitor (moderate)</li> <li>• P-gp inhibitor</li> </ul>	<ul style="list-style-type: none"> <li>• The Panel <b>recommends against</b> the use of CQ with or without AZM for the treatment of COVID-19 in hospitalized patients <b>(AI)</b>.</li> <li>• In nonhospitalized patients, the Panel <b>recommends against</b> the use of CQ with or without AZM for the treatment of COVID-19, except in a clinical trial <b>(AI)</b>.</li> <li>• The Panel <b>recommends against</b> using high-dose CQ (600 mg twice daily for 10 days) for the treatment of</li> </ul>

Drug Name	Dosing Regimens <i>The doses listed here are for approved indications or from reported experiences or clinical trials.</i>	Adverse Effects	Monitoring Parameters	Drug-Drug Interaction Potential	Panel's Recommendations, Comments, and Links to Clinical Trials
Chloroquine, continued		<ul style="list-style-type: none"> <li>Given the risk of heart rhythm problems, the FDA cautions against using CQ to treat COVID-19 outside of a hospital or a clinical trial.<sup>1</sup></li> </ul>			COVID-19 (AI). <ul style="list-style-type: none"> <li>Dose-dependent toxicity</li> <li>A list of clinical trials is available here: <a href="#">Chloroquine</a></li> </ul>
Hydroxychloroquine	<b>Adults:</b> <ul style="list-style-type: none"> <li>Various loading and maintenance doses have been reported in studies or in clinical care.</li> </ul> <b>Dose Previously Suggested in an EUA for Hospitalized Adults and Adolescents Weighing ≥50 kg:</b> <ul style="list-style-type: none"> <li>HCQ 800 mg PO once on Day 1, then HCQ 400 mg PO once daily for 4–7 days of total treatment. Treatment duration should be based on clinical evaluation.</li> </ul>	<ul style="list-style-type: none"> <li>Prolonged QTc interval, Torsades de Pointes, AV block, ventricular arrhythmia</li> <li>Gastrointestinal effects (e.g., nausea, vomiting, diarrhea)</li> <li>Hepatitis</li> <li>Hypoglycemia</li> <li>Myopathy</li> <li>Anxiety, agitation, hallucinations, psychosis</li> <li>Allergic reaction/rash</li> <li>Given the risk of heart rhythm problems, the FDA cautions against using HCQ to treat COVID-19 outside of a hospital or a clinical trial.<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>CBC, hepatic panel, blood glucose, SCr, potassium, magnesium</li> <li>Baseline ECG</li> <li>Follow-up ECG if HCQ is given with QTc-prolonging drugs (e.g., AZM) or if the patient has underlying cardiac disease</li> </ul>	<ul style="list-style-type: none"> <li>Additive effect with other drugs that prolong the QTc interval (including AZM) or that cause hypoglycemia</li> <li>CYP2D6 inhibitor (moderate)</li> <li>P-gp inhibitor</li> </ul>	<ul style="list-style-type: none"> <li>The Panel <b>recommends against</b> the use of HCQ with or without AZM for the treatment of COVID-19 in hospitalized patients (AI).</li> <li>In nonhospitalized patients, the Panel <b>recommends against</b> the use of HCQ with or without AZM for the treatment of COVID-19, except in a clinical trial (AI).</li> <li>Long elimination; half-life is 40–55 days.</li> <li>Dose-dependent toxicity</li> <li>A list of clinical trials is available here: <a href="#">Hydroxychloroquine</a></li> </ul>
Lopinavir/Ritonavir	<b>Adults:</b> <ul style="list-style-type: none"> <li>LPV 400 mg/RTV 100 mg PO twice daily for 10–14 days</li> </ul> <b>Neonates Aged ≥14 Days with a PMA ≥42 Weeks and Children Aged &lt;18 Years:</b> <ul style="list-style-type: none"> <li>LPV 300 mg/m<sup>2</sup> plus RTV 75 mg/m<sup>2</sup> (maximum dose: LPV 400 mg/RTV 100 mg) PO twice daily for a total of 7 days</li> </ul>	<ul style="list-style-type: none"> <li>Gastrointestinal effects (e.g., nausea, vomiting, diarrhea)</li> <li>Transaminase elevation</li> <li>QTc interval prolongation and Torsades de Pointes have been reported.</li> <li>PR interval prolongation</li> </ul>	<ul style="list-style-type: none"> <li>HIV antigen/antibody testing at baseline</li> <li>Serum transaminase levels</li> <li>Consider monitoring ECG when LPV/RTV</li> </ul>	<b>High Drug-Drug Interaction Potential</b> <i>Lopinavir:</i> <ul style="list-style-type: none"> <li>CYP3A4 inhibitor and substrate</li> </ul> <i>Ritonavir:</i> <ul style="list-style-type: none"> <li>CYP3A4 &gt; CYP2D6 substrate</li> </ul>	<ul style="list-style-type: none"> <li>The Panel <b>recommends against</b> using LPV/RTV (AI) or other HIV PIs (AIII) to treat COVID-19, except in a clinical trial.</li> <li>Liquid formulation is commercially available. Crushing LPV/RTV tablets may result in significantly</li> </ul>

Drug Name	Dosing Regimens <i>The doses listed here are for approved indications or from reported experiences or clinical trials.</i>	Adverse Effects	Monitoring Parameters	Drug-Drug Interaction Potential	Panel's Recommendations, Comments, and Links to Clinical Trials
Lopinavir/Ritonavir, continued			is given with other QTc-prolonging medications.	<ul style="list-style-type: none"> <li>• Potent CYP3A4 and CYP2D6 inhibitor</li> <li>• Inducer of UGT1A1 and CYP1A2, CYP2C8, CYP2C9, and CYP2C19</li> </ul>	<ul style="list-style-type: none"> <li>• decreased drug exposure (AUC ↓ 45%).<sup>2</sup></li> <li>• Use with caution in patients with hepatic impairment.</li> <li>• A list of clinical trials is available here: <a href="#">Lopinavir/Ritonavir</a></li> </ul>
<b>Remdesivir</b> <b>Note:</b> RDV is approved by the FDA for the treatment of COVID-19.	<p><b>For Hospitalized Adult and Pediatric Patients (Aged ≥12 Years and Weighing ≥40 kg)</b></p> <p><i>For Patients Who Are Not Mechanically Ventilated and/or on ECMO:</i></p> <ul style="list-style-type: none"> <li>• RDV 200 mg IV over 30–120 minutes on Day 1, followed by RDV 100 mg IV on Day 2 through Day 5</li> <li>• In patients who have not shown clinical improvement after 5 days of therapy, treatment may be extended up to 10 days.</li> </ul> <p><i>For Mechanically Ventilated Patients and/or Patients on ECMO:</i></p> <ul style="list-style-type: none"> <li>• RDV 200 mg IV over 30–120 minutes on Day 1, followed by RDV 100 mg IV on Day 2 through Day 10</li> </ul> <p><b>Suggested Dose in EUA<sup>a</sup> for Hospitalized Pediatric Patients Weighing 3.5 kg to &lt;40 kg or Aged &lt;12 Years and Weighing ≥3.5 kg</b></p> <p><i>For Patients Weighing 3.5 kg to &lt;40 kg:</i></p> <ul style="list-style-type: none"> <li>• RDV 5 mg/kg IV over 30–120 minutes on Day 1, followed by RDV 2.5 mg/kg once daily starting on Day 2</li> <li>• For patients who are not mechanically ventilated and/or on ECMO, the</li> </ul>	<ul style="list-style-type: none"> <li>• Nausea</li> <li>• ALT and AST elevations</li> <li>• Hypersensitivity</li> <li>• Increases in prothrombin time</li> <li>• Drug vehicle is SBECD, which has been associated with renal toxicity. SBECD accumulation may occur in patients with moderate or severe renal impairment.</li> <li>• Each 100 mg vial of remdesivir lyophilized powder contains 3 g of SBECD and each 100 mg/20 mL vial of remdesivir solution contains 6 g of SBECD.</li> </ul>	<ul style="list-style-type: none"> <li>• Infusion reactions</li> <li>• Renal function, hepatic function, and prothrombin time should be monitored before and during treatment as clinically indicated</li> <li>• <b>Not recommended</b> if eGFR is &lt;30 mL/min</li> <li>• RDV may need to be discontinued if ALT levels increase to &gt;10 times the ULN and should be discontinued if there is an increase in ALT level and signs or symptoms of liver inflammation are observed.<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Clinical drug-drug interaction studies of RDV have not been conducted.</li> <li>• In vitro, RDV is a substrate of CYP3A4, OATP1B1, and P-gp and an inhibitor of CYP3A4, OATP1B1, OATP1B3, and MATE1.<sup>3</sup></li> <li>• Minimal to no reduction in RDV exposure is expected when RDV is coadministered with dexamethasone (Gilead Sciences, written communication, July 2020).</li> <li>• CQ or HCQ may decrease the antiviral activity of RDV; coadministration of these drugs <b>is not recommended</b>.<sup>3</sup></li> </ul>	<ul style="list-style-type: none"> <li>• See <a href="#">Therapeutic Management of Patients with COVID-19</a> for recommendations on using remdesivir with or without dexamethasone.</li> <li>• RDV should be administered in a hospital or a health care setting that can provide a similar level of care to an inpatient hospital.</li> </ul> <p><b>Availability:</b></p> <ul style="list-style-type: none"> <li>• RDV is approved by the FDA for the treatment of COVID-19 in hospitalized adult and pediatric patients (aged ≥12 years and weighing ≥40 kg).</li> <li>• An EUA<sup>a</sup> is available for hospitalized pediatric patients weighing 3.5 kg to &lt;40 kg or aged &lt;12 years and weighing ≥3.5 kg.</li> <li>• A list of clinical trials is available here: <a href="#">Remdesivir</a></li> </ul>

Drug Name	Dosing Regimens <i>The doses listed here are for approved indications or from reported experiences or clinical trials.</i>	Adverse Effects	Monitoring Parameters	Drug-Drug Interaction Potential	Panel's Recommendations, Comments, and Links to Clinical Trials
Remdesivir, continued	<p>recommended treatment duration is 5 days. If patients have not shown clinical improvement after 5 days of therapy, treatment may be extended up to 10 days.</p> <ul style="list-style-type: none"> <li>For mechanically ventilated patients and/or patients on ECMO, the recommended treatment duration is 10 days.</li> </ul> <p><i>For Patients Aged &lt;12 Years and Weighing ≥40 kg:</i></p> <ul style="list-style-type: none"> <li>Same dose as for adults and children aged &gt;12 years and weighing &gt;40 kg</li> </ul>			<ul style="list-style-type: none"> <li>No significant interaction is expected between RDV and oseltamivir or baloxavir (Gilead Sciences, personal and written communications, August and September 2020).</li> </ul>	

<sup>a</sup> The FDA EUA permits the emergency use of RDV for the treatment of suspected COVID-19 or laboratory-confirmed SARS-CoV-2 infection in hospitalized pediatric patients weighing 3.5 kg to <40 kg or aged <12 years and weighing ≥3.5 kg.<sup>4</sup>

**Key:** AE = adverse effect; ALT = alanine transaminase; AST = aspartate aminotransferase; AUC = area under the curve; AV = atrioventricular; AZM = azithromycin; CBC = complete blood count; CQ = chloroquine; CYP = cytochrome P; ECG = electrocardiogram; ECMO = extracorporeal membrane oxygenation; eGFR = estimated glomerular filtration rate; EUA = Emergency Use Authorization; FDA = Food and Drug Administration; G6PD = glucose-6-phosphate dehydrogenase; HCQ = hydroxychloroquine; HIV = human immunodeficiency virus; INR = international normalized ratio; IV = intravenous; LPV = lopinavir; LPV/RTV = lopinavir/ritonavir; OATP = organic anion transporter polypeptide; the Panel = the COVID-19 Treatment Guidelines Panel; P-gp = P-glycoprotein; PI = protease inhibitor; PMA = postmenstrual age; PO = orally; PT = prothrombin time; RDV = remdesivir; RTV = ritonavir; SARS-CoV-2 = severe acute respiratory syndrome coronavirus 2; SBECD = sulfobutylether-beta-cyclodextrin; SCr = serum creatinine; UGT = uridine diphosphate glucuronosyltransferase; ULN = upper limit of normal

## References

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