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| Hospitalized but does not require suppl O2 | No ccs  No rec for or against remdes, for pts at high risk of dz progression, t/c remdesivir |
| Hospitalized and reqs suppl O2 | Use one of the following:   * Remdes if reqs min suppl O2 * Dex plus remdes if requires increasing O2 reqs * Dex when combo w/ remdes can’t be used or not avail |
| Hospitalized and reqs HFNC or NIV | Use one of the following:   * Dex * Dex plus remdes   If recently hospitalized and rapidly increasing O2 rews and systemic inflammation   * Add tocilizumab or baricitini. If not avail, can use:   + tofacitinib instead of baricitinib   + sarilumab instead of tocilizumab |
| Mech vent or ECMO | If w/in 24 hrs of ICU admission:   * Dex and tocilizumab   + If tocilizumab not avail then sarilumab |
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| Regimens | |
| Remdesivir | 200 mg IV x1, the 100 mg IV qd x4 days or until hospital d/c |
| Dexamethasone | 6 mg IV or PO daily x10 days or until hospital d/c |
| Tocilizumab | 8 mg/kg actual body weight x1. Can give 2nd dose 8 hrs after first dose if no clinical improvement. |
| Baricitinib | 4 mg PO daily, adjust for GFR |
| Sarilumab | If tocilizumab not avail or can’t use  400 mg in 100 mL NS IV over 1 hr |
| Tofacitinib | If baricitinib not avail  10 mg PO BID x14 days or until hospital d/c |

NIH currently recommends ***against***

* tocilizumab and baricitinib at the same time
* siltuximab
* A/c antiplatelet therapy unless indicated for other (non-COVID-19) condition
* No data to support measuring coagulation markers such as d-dimer, fibrinogen, PT, platelet count, unless needed for other reasons. Insufficient data to recommend using the #s to guide mgmt..

Sources

* NIH “COVID-19 Treatment Guidelines” (covid19treatmentguidelines.pdf), <https://files.covid19treatmentguidelines.nih.gov/guidelines/covid19treatmentguidelines.pdf>