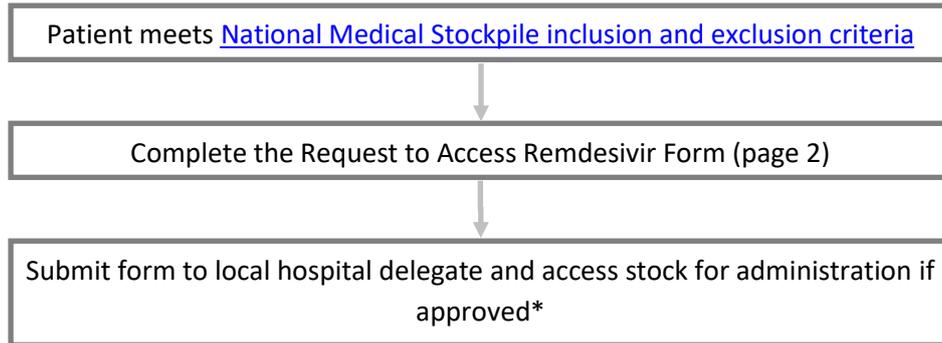


REQUEST TO ACCESS REMDESIVIR

- A streamlined approach has been developed to assist access to remdesivir
- Remdesivir is only available for patients who meet the criteria listed on page 2.
- Access to stock will require completion of the Request to Access Remdesivir Form (page 2) by the prescriber and must fulfil all required criteria.



***NOTE:** Stock will be supplied by Alfred Pharmacy and organised by the local hospital pharmacy department for approved patients

REQUEST TO ACCESS REMDESIVIR

PATIENT DETAILS

Patient Initials _____

Patient MRN _____

Patient DOB (dd/mm/yy) _____

Hospital _____

Is this an initial or repeat application?

Initial – 5 days (6 vials)

Request for additional duration – 5 days (5 vials)

PRESCRIBER DETAILS

Prescriber Full Name _____

Prescriber Email _____

Prescriber Job Title _____

Phone Number _____

SEVERITY (tick the applicable severity)

Supplemental low-flow oxygen

Noninvasive ventilation or high-flow oxygen

Mechanical ventilation

ACCESS CRITERIA (tick each criteria to confirm the access criteria has been met)

Age ≥ 18 years, or aged ≥ 12 and < 18 years of age and weighing ≥ 40 kg.

Hospitalised with confirmed SARS-CoV2 or known contact of confirmed case with syndrome consistent with coronavirus disease (COVID-19) awaiting confirmation by diagnostic testing.

Oxygen saturation (SpO₂) $\leq 92\%$ on room air and requiring supplemental oxygen

Alanine aminotransferase (ALT) < 5 x upper limit of normal (ULN) by local laboratory measure and/or ALT < 3 x ULN and bilirubin < 2 x ULN

eGFR > 30 mL/min and not on dialysis or continuous veno-venous haemofiltration

EXCLUSION CRITERIA (tick each criteria to confirm that the exclusion criteria DOES NOT apply)

Evidence of multiorgan failure including but not limited to coagulopathy (significant thrombocytopenia), hepatic failure (elevated bilirubin) or renal failure (low urine output or estimated glomerular filtration rate (eGFR) < 30 mL/min), or significant cardiomyopathy (low cardiac output)

Receiving ECMO

Mechanical ventilation for longer than 48 hours at time of application

Known hypersensitivity to the study drug, the metabolites, or formulation excipient

I declare that the above information is accurate at the time of completion and agree to provide patient outcome information when requested by the Victorian Department of Health.

I declare that patient consent for treatment with remdesivir has been obtained.

I declare that all local hospital approval processes for access to remdesivir have been obtained prior to application

REQUEST TO ACCESS REMDESIVIR

Please EMAIL the completed request form to:

- 1) The nominated hospital pharmacy delegate for your hospital _____
AND
- 2) pharmdist@alfred.org.au