Paxlovid Order Form

Patient Name: _____ Patient's Age: _____

Patient's DOB: _____ Patient's Contact Number: _____

***All Questions Must be Answered before Order is Valid* Fax Completed Form to 270-417-6705**

Has patient had a positive Covid-19 test? Yes or No (If No, patient does NOT qualify)

What date did the positive test occur? _____.

Date of symptom onset? (must be within 5 days)_____.

If patient has any of the following contraindications then Paxlovid is not a treatment option.

- Less than 12 years of age
- Weight under 40 kilograms
- Hospitalized

Select Appropriate Order Below:

NORMAL RENAL FUNCTION

☐ GFR ≥60 ml/min

PAXLOVID - 300 mg nirmatrelvir (two 150 mg tablets) with 100 mg ritonavir (one 100 mg tablet) with all three tablets taken together orally twice daily for 5 days.
Nirmatrelvir 150 mg tablets: #20
Ritonavir 100 mg tablets: #10

RENAL ADJUSTMENTS

☐ GFR ≥30 to <60 ml/min

PAXLOVID - 150 mg nirmatrelvir (one 150 mg tablet) with 100 mg ritonavir (one 100 mg tablet) with both tablets taken together orally twice daily for 5 days.
Nirmatrelvir 150 mg tablets: #10
Ritonavir 100 mg tablets: #10

☐ GFR <30 ml/min – NOT RECOMMENDED

References: Paxlovid EUA

*Note to Provider: Paxlovid is a CYP3A inhibitor and may lead to clinically significant drug interactions. See the current EUA Fact Sheet for Healthcare Providers for significant drug interactions including **contraindicated** drugs.*

Has the Patient and/or Caregiver received "Fact Sheet" information in written or verbal form? Yes or No
Can be obtained by visiting the Pfizer website by clicking here.

Has Patient been informed of alternatives to receiving Paxlovid? Yes or No

Has the Patient been informed that Paxlovid is an unapproved drug that is authorized for use under the Emergency Use Authorization? Yes or No

Provider Printed Name: _____

Provider Signature: _____

By signing above you are authorizing the patient to receive Paxlovid based on availability.