

Request to Access Remdesivir: SEVERE DISEASE requiring OXYGEN – Adults

Please email completed forms to CTWG@health.qld.gov.au and nominated pharmacy delegate at your hospital

Please note: this medication is regulated by the National Medical Stockpile. Access to stock requires completion of this form and confirmation by the prescriber that the patient fulfils required criteria.

Supply of COVID-19 therapeutics is currently through the National Medical Stockpile (NMS) and availability may fluctuate with demand and constraints in the supply chain.

Please check your patient meets eligibility for these medicines prior to completing the form(s).

PATIENT DETAILS

Patient initials:

URN:

Patient DOB:

Gender:

Patient weight:

HHS:

Hospital/Facility:

Is the patient pregnant?

Is the patient breastfeeding?

ACCESS CRITERIA

The patient must meet ALL access criteria:

Confirmed SARS-CoV-2 positive

Age \geq 18 years

Requires Oxygen SpO₂ \leq 92% on room air

NOT ventilated (invasive or non-invasive mechanical ventilation or ECMO)

ALT/AST < 5x upper limit of normal (ULN)

ADMINISTRATION

Infusion start date:

COVID TEST

Date of positive test

Test type

Pathology provider

Date of symptom onset

VACCINATION

Vaccination status

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IMMUNOSUPPRESSION

Please select the patient's immunosuppression status (if applicable)

Solid organ transplant on immunosuppressive therapy

Specify organ:

Haematopoietic stem cell transplant

Please select:

Active haematological malignancy

Non haematological malignancy on current active treatment

HIV with CD4 count < 250 cells/microlitre or unable to be established on effective treatment

Primary immunodeficiency

Please specify immunodeficiency:

On immunosuppressive therapy

Please specify immunosuppressant(s):

RISK FACTORS

Select applicable risk factors

Age ≥ 50 years

Aboriginal or Torres Strait Islander ≥ 30 years

Obesity (BMI ≥ 30 kg/m²)

Renal impairment (eGFR < 60 mL/min)

Serious cardiac conditions (heart failure, CAD, cardiomyopathies, hypertension)

Respiratory compromise (e.g. COPD, mod-severe asthma, bronchiectasis)

Diabetes (Type I or II requiring medication)

Medical related technologic dependence (BiPAP, other ventilation not related to COVID-19)

Neurodevelopment disorders (including Cerebral Palsy, Down's Syndrome etc)

Sickle Cell Disease

Patients with neuromuscular disease with respiratory muscle involvement

Disability with multiple comorbidities or frailty

Neurological conditions (e.g. stroke, dementia, demyelinating condition)

Cirrhosis

Patient in RACF

Lack of access to higher level healthcare or remote (MMM Cat 5 or above)

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PRESCRIBER DETAILS

Prescriber full name:

Email:

Position:

Phone:

APPROVER DETAILS (if required at your site)

Name of approving Infectious Diseases Physician/COVID delegate:

Email:

Position:

Phone:

Date of approval:

Name of pharmacist consulted:

Acknowledgement

I declare that the information provided is accurate at the time of completion

I declare that I have discussed the risks and benefits of treatment with the patient and/or their carer and provided a Patient Information Leaflet

I agree to report any adverse reactions via the local reporting process

I agree to provide outcome information when requested