COVID-19 Therapy Update: Appropriate Referral

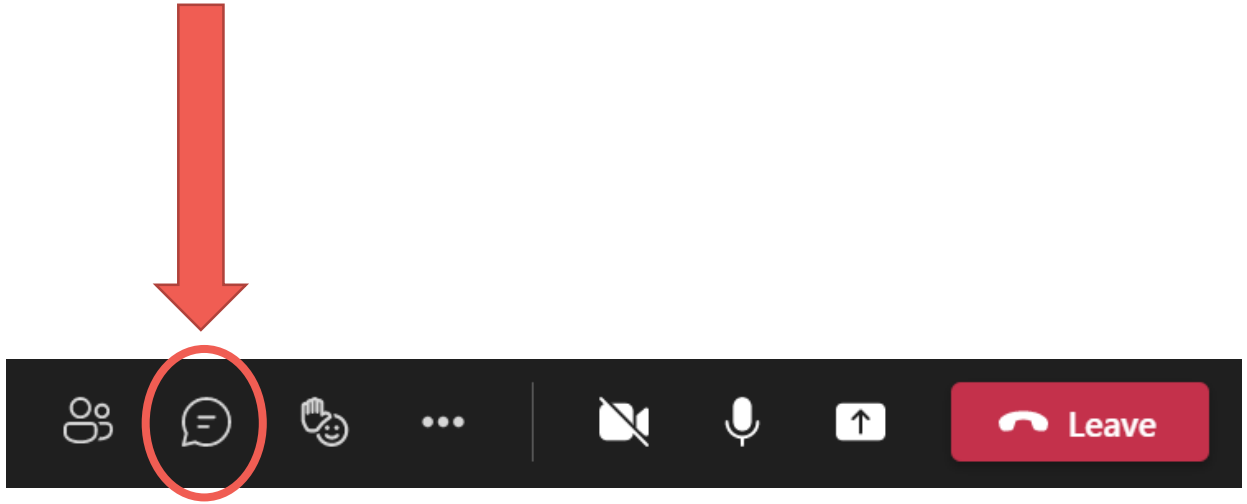
May 3, 2022

Welcome

Jennifer Khelil, DO, MBA
Senior VP and Chief Medical Officer

Housekeeping

- This program will be recorded
- All participants should have their microphones muted
- Please send questions for the presenters via the chat function



Virtua Health

Covid-19 Outpatient Treatment

Marty Topiel, MD, FSHEA, Infection Prevention Officer

May 3, 2022

Links to Treatment Guidelines

- Below are links to updated treatment guidelines and recommendations:

- https://aspr.hhs.gov/COVID-19/Therapeutics/Documents/COVID-Therapeutics-Decision-Aid.pdf

- https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/

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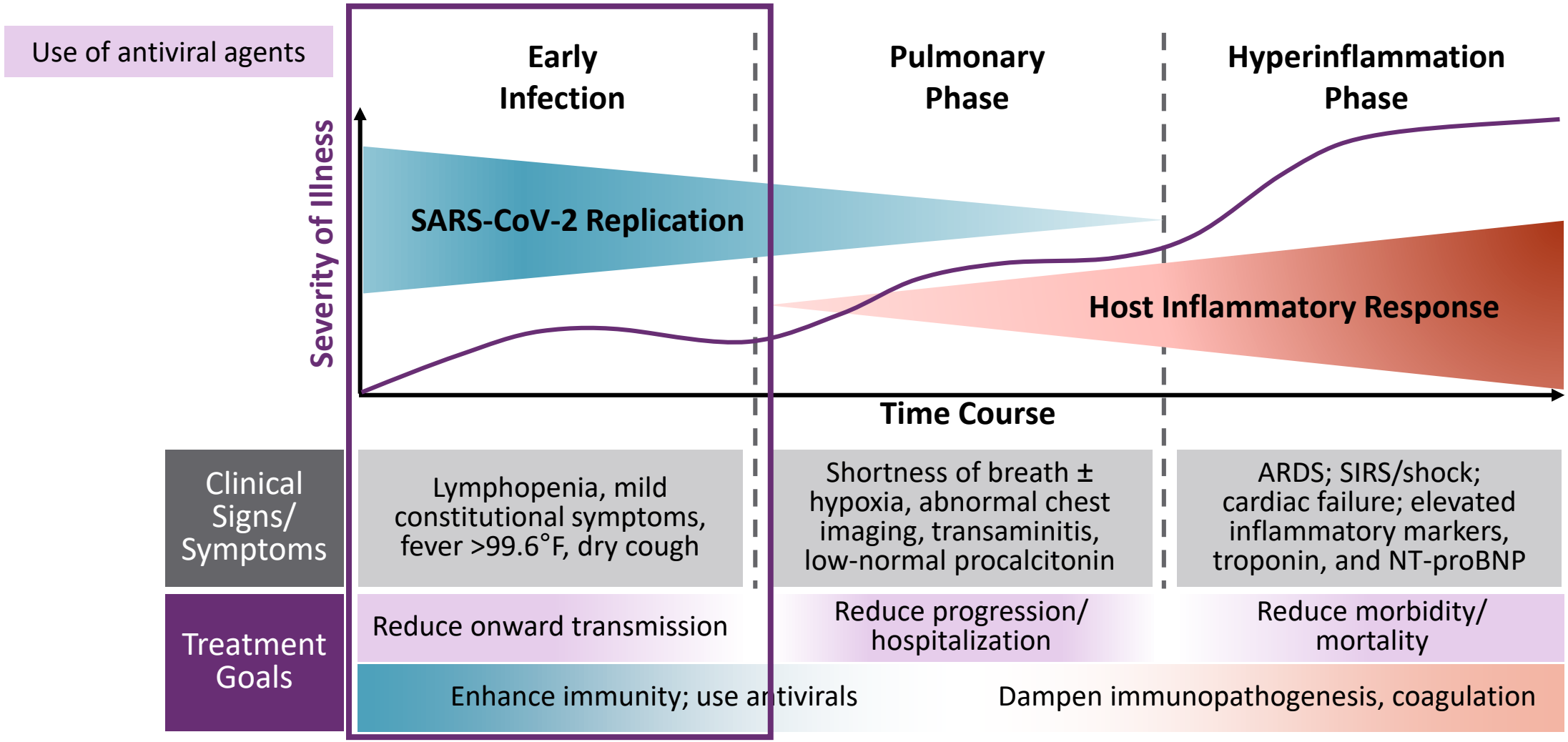
Therapeutic Classes Dictated by SARS-CoV-2 Pathogenesis



NIH COVID-19 treatment guidelines. Clinical management summary. Last updated April 8, 2022.
Siddiqi. J Heart Lung Transplant. 2020;39:405.

Slide credit: clinicaloptions.com

Currently Available Anti-SARS-COV-2 Treatments: Antivirals

Drug	Route	Age groups authorized for treatment	Timing of Treatment	Effectiveness	Activity Against Variants Currently Circulating
Nirmatrelvir 300 mg with ritonavir 100 mg (Paxlovid) Orally twice daily for 5 days	Oral	12 years and older and weighing at least 40 kg	As soon as possible, but within 5 days of symptom onset	Compared to placebo, a relative risk reduction of 89% in hospitalizations or deaths.	Effective against Delta and Omicron
Remdesivir (Veklury) 200 mg IV on Day 1, followed by 100 mg IV daily on Days 2 and 3	Intravenous	FDA approved in 12 years and older and weighing at least 40 kg; EUA for <12 years of age weighing 3.5 to 40 kg	As soon as possible, but within 7 days of symptom onset	Compared to placebo, a relative risk reduction of 87% in hospitalizations or deaths.	Effective against Delta and Omicron
Molnupiravir (Legevrio) 800 mg Orally twice daily for 5 days	Oral	18 years and older	As soon as possible, but within 5 days of symptom onset	Compared to placebo, a relative risk reduction of 30% in hospitalizations or deaths.	Effective against Delta and Omicron

- Merck and Biotherapeutics Molnupiravir Update
- Pfizer Paxlovid Study Interim Analysis

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Therapeutic Management of Non-hospitalized Adults w/COVID-19

PATIENT DISPOSITION	PANEL'S RECOMMENDATIONS
Does Not Require Hospitalization or Supplemental Oxygen	All patients should be offered symptomatic management **(AIII)**. For patients who are at high risk of progressing to severe COVID-19,[a] use 1 of the following treatment options: **Preferred Therapies** *Listed in order of preference:* • **Ritonavir-boosted nirmatrelvir (Paxlovid)[b,c] (AIIa)** • **Remdesivir[c,d] (BIIa)** **Alternative Therapies** *For use ONLY when neither of the preferred therapies are available, feasible to use, or clinically appropriate. Listed in alphabetical order:* • **Bebtelovimab[e] (CIII)** • **Molnupiravir[c,f] (CIIa)** The Panel **recommends against** the use of **dexamethasone[g]** or **other systemic corticosteroids** in the absence of another indication **(AIII)**.

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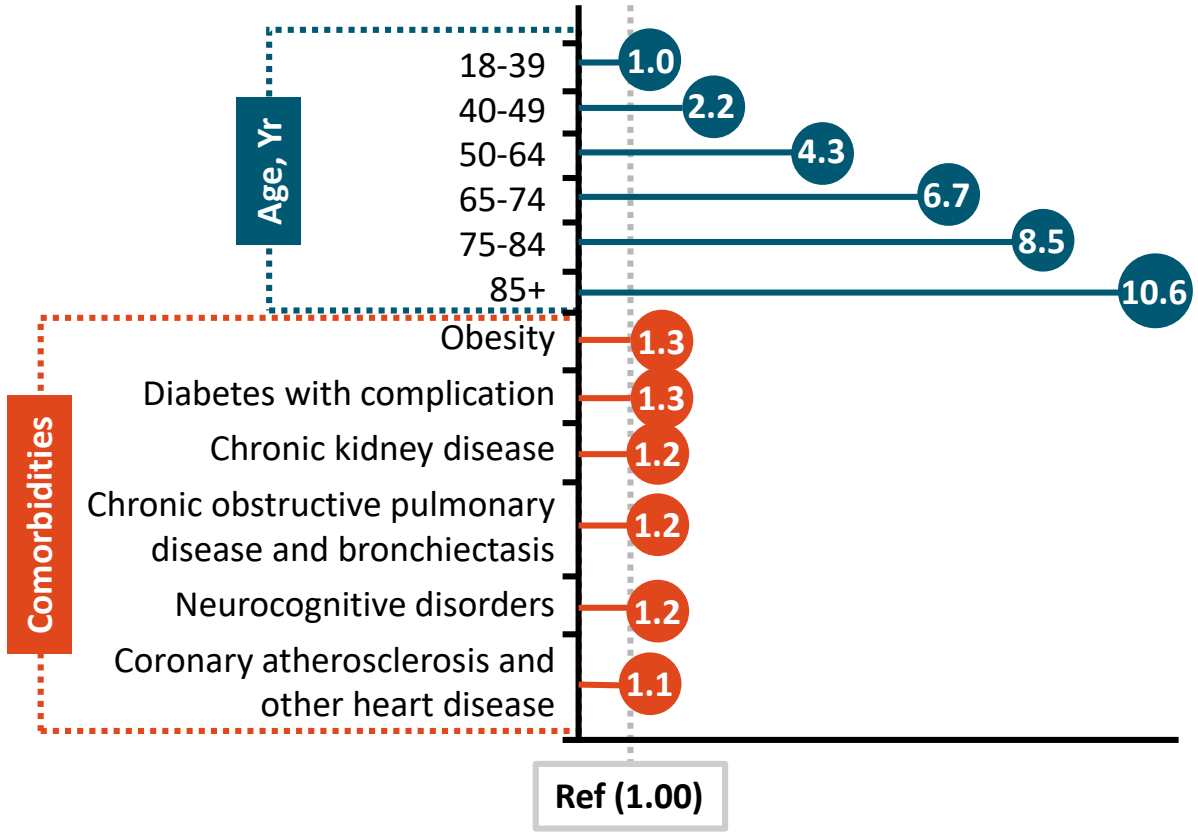
Age Is an Important Risk Factor for Severe COVID-19

COVID-19 Death Risk Ratio for Select Age Group and Comorbid Conditions



- **EPIC-HR and MOVe-OUT High-Risk Criteria:**
  - ≥60 yr of age
  - Chronic pulmonary disease
  - Overweight or obese
  - Chronic kidney disease
  - Cardiovascular disease
  - Neurodevelopmental disorders
  - Medically related technologic dependence
  - Tobacco smoker
  - Immunosuppression
  - Sickle cell disease
  - Diabetes
  - Active cancer

cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html.
Hammond. NEJM. 2022;[Epub]. Bernal. NEJM. 2022;386:509.

Slide credit: clinicaloptions.com

Preferred Anti–SARS-CoV-2 Treatment Options for Nonhospitalized Patients

- For nonhospitalized adult and adolescent patients with mild to moderate COVID-19 who are at high risk of progression to severe disease; **listed in order of preference**

Anti–SARS-CoV-2 Treatment (in Order of Preference)	Population	Clinical Considerations
Nirmatrelvir 300 mg (two 150-mg tablets) + 100 mg ritonavir tablet PO BID x 5 days	Age ≥12 yr and weighing ≥40 kg	▪ Use within 5 days of symptom onset ▪ Drug interactions ▪ Renal dosing if eGFR 30-59 mL/min ▪ HIV activity of ritonavir
Remdesivir 200 mg IV on Day 1, followed by remdesivir 100 mg IV daily on Days 2 and 3	Age ≥12 yr and weighing ≥40 kg	▪ Use within 7 days symptom onset ▪ Must be administered in a healthcare setting

- Clinical trials are needed to determine whether combination therapy (with antivirals or antivirals with monoclonal antibodies) has a role in the treatment of SARS-CoV-2 infection

- For nonhospitalized **pediatric patients** age <12 yr or weighing <40 kg, can consider **IV remdesivir** if started within 7 days of symptom onset based on updated EUA

covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/
covid19treatmentguidelines.nih.gov/therapies/statement-on-bebtelovimab/
covid19treatmentguidelines.nih.gov/therapies/antiviral-therapy/remdesivir/

CCO

Slide credit: clinicaloptions.com

EPIC-HR: Day 28 Efficacy Analysis

- In nonhospitalized, at-risk patients with mild to moderate COVID-19, nirmatrelvir + RTV dosed every 12 hr for 5 days **reduced risk of hospitalization or death by 89%** (*P* = .001) when started within 3 days of symptom onset

Outcome	Started By Day 3			Started By Day 5		
	Nirmatrelvir + RTV (n = 697)	Placebo (n = 682)	*P* Value	Nirmatrelvir + RTV (n = 1039)	Placebo (n = 1046)	*P* Value
Hospitalization or death, n (%)	5 (0.72)	44 (6.45)	<.001	8 (0.77)	66 (6.31)	<.0001
Deaths, n (%)	0	9 (1.32)	NR	0	12 (1.15)	NR

- Safety analysis (N = 2224): fewer serious AEs and study drug discontinuation with nirmatrelvir + RTV vs placebo (1.6% vs 6.6% and 2.1% vs 4.2%, respectively)

- Due to positive interim results, DSMB stopped recruitment early
- EUA in nonhospitalized patients issued by the FDA on December 22, 2021

Hammond. NEJM. 2022;[Epub].

Slide credit: clinicaloptions.com

Liverpool Drug Interactions Group

Interactions with Essential Medicines & Nirmatrelvir/ritonavir (NMV/r)

Charts produced 8 March 2022

Please check www.covid19-druginteractions.org for updates.

Interaction tables - refer to page 2 for legend, notes and abbreviations

Please note that if a drug is not listed it cannot automatically be assumed it is safe to coadminister.
Drug interaction data for many agents are limited or absent; therefore, risk-benefit assessment for any individual patient rests with prescribers.
Management of interactions with nirmatrelvir/ritonavir (Paxlovid) may be complex and full details should be obtained from the website where possible.

Analgesics	
	Codeine
	Diclofenac
☐	Fentanyl
	Hydromorphone
	Ibuprofen
	Mefenamic acid
	Morphine
☐	Oxycodone
	Paracetamol
	Tramadol
Antiarrhythmics	
!	Amiodarone
☐	Lidocaine
Antibacterials	
	Amikacin
	Amoxicillin
	Ampicillin
☐	Bedaquiline
	Cefalexin
	Cefazolin
	Cefixime
	Cefotaxime
	Ceftriaxone
	Chloramphenicol
	Ciprofloxacin
	Clarithromycin (a)
	Clindamycin
	Clofazimine
	Cloxacillin
	Cycloserine
	Dapsone
☐	Delamanid
	Doxycycline
☐	Erythromycin
	Ethambutol
	Ethionamide
	Gentamicin
	Imipenem/cilastatin
	Isoniazid
	Kanamycin
	Levofloxacin
	Linezolid
	Meropenem
	Metronidazole
	Moxifloxacin
	Nitrofurantoin
	Ofloxacin
	Para-aminosalicylic acid
	Penicillins
	Piperacillin
	Pyrazinamide
☐	Rifabutin (b)
✖	Rifampicin
✖	Rifapentine
	Spectinomycin
	Streptomycin
	Sulfadiazine
	Tazobactam
	Tetracyclines
	Trimethoprim/ sulfamethoxazole
	Vancomycin

Anticoagulants/antiplatelets	
	Apixaban
	Aspirin (antiplatelet)
	Clopidogrel (stented) (c)
	Dabigatran (a)
	Dalteparin
	Edoxaban (d)
	Enoxaparin
	Heparin
	Rivaroxaban
	Streptokinase
☐	Warfarin
Anticonvulsants	
✖	Carbamazepine
	Clonazepam
☐	Ethosuximide
	Lamotrigine
✖	Phenobarbital
✖	Phenytoin
	Valproate
Antidepressants	
	Amitriptyline
	Clomipramine
	Fluoxetine
	Lithium
Antidiabetics	
	Glibenclamide
	Gliclazide
	Insulin
	Metformin
Antifungals	
	Amphotericin B
	Fluconazole
	Flucytosine
	Griseofulvin
	Itraconazole (e)
	Ketoconazole (e)
	Nystatin
☐	Voriconazole
Antimalarials	
☐	Amodiaquine
	Artemether
	Artesunate
	Atovaquone
	Lumefantrine
☐	Mefloquine
☐	Piperaquine
	Primaquine
	Proguanil
☐	Quinine
Antipsychotics	
	Chlorpromazine
	Clozapine
	Fluphenazine
☐	Haloperidol
☐	Risperidone
Anxiolytics	
	Diazepam
	Lorazepam
	Midazolam

Beta blockers	
	Atenolol
	Bisoprolol
	Carvedilol
	Metoprolol
	Propranolol
	Timolol
Bronchodilators	
	Aminophylline
	Ipratropium bromide
	Salmeterol
Calcium channel blockers	
	Amlodipine
	Nifedipine
	Verapamil
Cancer drugs	
☐	Dasatinib (f)
☐	Erlotinib (g)
☐	Imatinib (h)
	Methotrexate
☐	Vinblastine (i)
Contraceptives	
	Ethinylestradiol
	Etonogestrel (IMP)
	Etonogestrel (VR)
	Levonorgestrel (COC)
	Levonorgestrel (EC)
	Levonorgestrel (IDU)
	Levonorgestrel (POP)
	Medroxyprogesterone (depot injection)
	Norethisterone (COC)
	Norethisterone (IM)
	Norethisterone (POP)
	Norgestrel (COC)
COVID19 therapies	
	Budesonide (inhaled)
	Convalescent plasma
	Dexamethasone
	Hydrocortisone
	Infliximab
	Methylprednisolone
	COVID19 vaccines
Gastrointestinal agents	
☐	Aprepitant
	Domperidone
	Lactulose
	Loperamide
	Mesalazine
	Metoclopramide
	Omeprazole
	Ondansetron
	Ranitidine
	Senna
HCV antivirals	
	Glecaprevir/pibrentasvir
	Ledipasvir/sofosbuvir
	Ombitasvir/paritaprevir/r
	Sofosbuvir/velpatasvir
Herbals/supplements	
	Folic acid
	Magnesium
	St John's Wort

HIV antiretrovirals	
	Abacavir
	Atazanavir/ritonavir
	Darunavir/ritonavir
	Dolutegravir
	Efavirenz
	Emtricitabine
	Lamivudine
	Lopinavir/ritonavir
	Nevirapine
	Raltegravir
	Tenofovir alafenamide
	Tenofovir-DF
	Zidovudine
Hypertension/heart failure	
	Amiloride
☐	Digoxin
	Dopamine
	Enalapril
	Furosemide
	Hydrochlorothiazide
	Isosorbide dinitrate
	Lisinopril
	Losartan
	Methyldopa
	Spironolactone
Immunosuppressants	
	Azathioprine
	Ciclosporin
	Everolimus
Lipid lowering agents	
☐	Atorvastatin
	Fluvastatin
	Lovastatin
	Simvastatin
Others	
	Allopurinol
	Ergometrine
	Levodopa
	Levothyroxine
Steroids	
	Beclomethasone
	Betamethasone
	Fludrocortisone
	Prednisolone
	Testosterone
☐	Triamcinolone

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Liverpool Drug Interactions Group

Interactions with Essential Medicines & Nirmatrelvir/ritonavir (NMV/r)

Charts produced 8 March 2022 *Page 2 of 2*

Please check www.covid19-druginteractions.org for updates.

Legend

Colour/Symbol		Recommendation for NMV/r use
!	Do not co-administer	Do not use NMV/r ⇒ alternative COVID-19 therapy Risk of serious toxicity. Stopping the drug does not mitigate the interaction due to its prolonged half-life.
✖	Do not co-administer	Do not use NMV/r ⇒ alternative COVID-19 therapy Strong inducer can jeopardize NMV/r efficacy due to persisting induction after stopping the drug.
	Do not co-administer	NMV/r use ONLY possible if drug is paused or replaced by a non-interacting drug Risk of serious toxicity. Only start NMV/r if the drug can be safely paused or replaced. Drug can be resumed 3 days after completing NMV/r therapy.
☐	Potential interaction Dose adjustment and/or close monitoring required.	Stop or replace drug if possible or consult specialist for dose adjustment/monitoring to allow use with NMV/r Ideally, only start NMV/r if the drug can be safely paused or replaced. Alternatively, dose adjust/monitor. Refer to www.covid19-druginteractions.org for detailed information.
	Potential interaction Manageable by counselling patient	Proceed with NMV/r Interaction manageable by counselling the patient about potential interaction and advising to temporarily stop the drug if feeling unwell.
	Weak interaction No action needed	Proceed with NMV/r Drug metabolized partially by CYP3A4 or with low risk of adverse event from interaction.
	No interaction expected	Proceed with NMV/r

Notes

a No dose reduction or monitoring in patients with normal renal function.

b Rifabutin dosed 150 mg once daily with NMV/r.

c Ritonavir decreases clopidogrel efficacy therefore NMV/r cannot be prescribed in high risk situation (i.e. initial period (at least 6 weeks) post coronary stenting). NMV/r is allowed if clopidogrel is used outside this period or if clopidogrel is used as alternative to aspirin (intolerant patients).

d The US product label for edoxaban advises no dose adjustment is needed for edoxaban in the presence of a P-gp inhibitor, such as ritonavir.

e Itraconazole or ketoconazole should not be used at doses >200 mg/day.

f The decision to pause or dose adjust dasatinib should be made in conjunction with the patient's oncologist.
Chronic phase chronic myelogenous leukaemia: pause dasatinib and restart 3 days after completing NMV/r. Alternatively, consider reducing dasatinib dose to 20 mg (in patients receiving 100 mg daily) or 40 mg (in patients receiving 140 mg daily) and monitor for toxicity.
Accelerated or blast phase chronic myelogenous leukaemia: do not coadminister, use alternative COVID-19 therapy.

g The decision to pause or dose adjust erlotinib should be made in conjunction with the patient's oncologist.
If it is decided to pause treatment, restart erlotinib 3 days after completing NMV/r treatment. If pausing erlotinib treatment is not feasible, continue full dose erlotinib with patient self-monitoring for rash and diarrhoea. If these do occur, reduce erlotinib dose in 50 mg decrements or re-assess for a short pause.

h The decision to pause imatinib should be made in conjunction with the patient's oncologist. If it is decided to hold treatment, restart imatinib 3 days after completing NMV/r treatment. Alternatively, imatinib may be coadministered with monitoring for adverse effects (fluid retention, nausea and neutropenia). NMV/r is expected to have a modest effect on imatinib exposure. Coadministration with ritonavir (600 mg once daily) for 3 days did not significantly alter imatinib exposure (*van Erp NP et al. Clin Cancer Res. 2007;13(24):7394-400*).

i The decision to pause or dose adjust vinblastine should be made in conjunction with the patient's oncologist. Vinblastine may be paused in the context of acute infection. Restart vinblastine 3 days after completing NMV/r treatment. Alternatively, vinblastine may be coadministered with close monitoring for haematologic toxicity and neurotoxicity. Some providers may wish to empirically reduce vinblastine dose, especially in patients who have previously experienced or are at high risk for toxicity.

Contraceptive Abbreviations

COC = combined oral contraceptive
EC = emergency contraception
IDU = intrauterine device
IM = intramuscular
IMP = implant
POP = progestin only contraceptive pill
VR = vaginal ring.

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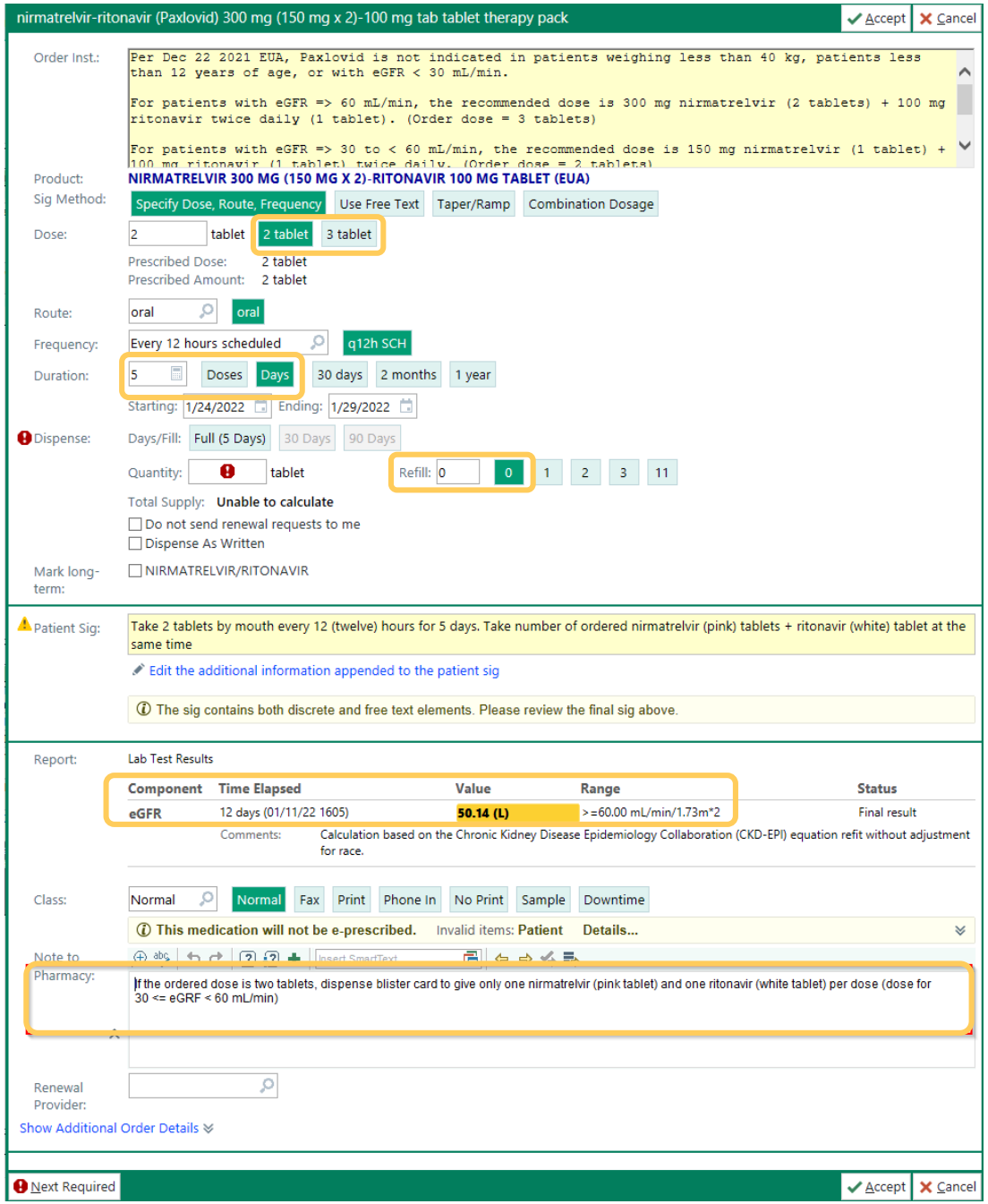

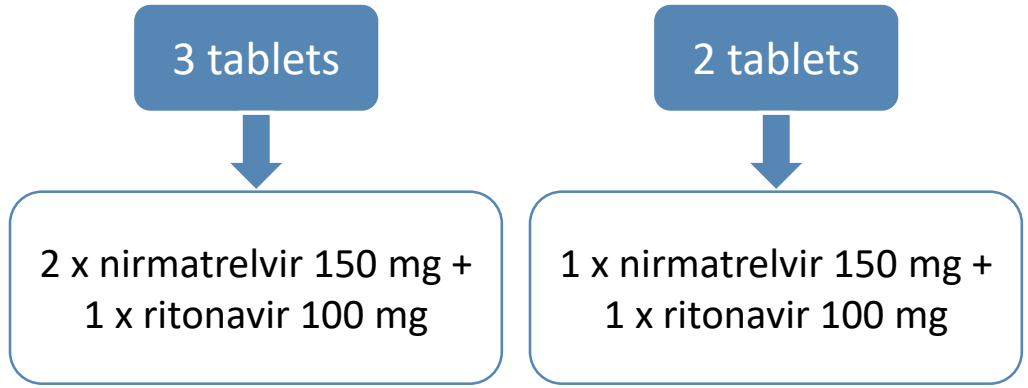

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Paxlovid

- COVID Therapy Locator Websites:
- https://covid-19-therapeutics-locator-dhhs.hub.arcgis.com/
- https://healthdata.gov/Health/COVID-19-Public-Therapeutic-Locator/rxn6-qnx8/data

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Inhibit CYP3A

- Alpha1-adrenoreceptor antagonist: alfuzosin
- Analgesics: pethidine, propoxyphene
- Antianginal: ranolazine
- Antiarrhythmic: amiodarone, dronedarone, flecainide, propafenone, quinidine
- Anti-gout: colchicine
- Antipsychotics: lurasidone, pimozide, clozapine
- Ergot derivatives: dihydroergotamine, ergotamine, methylergonovine • HMG-CoA reductase inhibitors: lovastatin, simvastatin
- PDE5 inhibitor: sildenafil (Revatio®) when used for pulmonary arterial hypertension (PAH)
- Sedative/hypnotics: triazolam, oral midazolam

PINETREE: Day 28 Efficacy

- Baseline characteristics balanced across treatment arms
- In high-risk, nonhospitalized participants, **3-day course of remdesivir prevented COVID-19–related medically attended visits, hospitalization, or death**
- **No difference** between remdesivir vs placebo in TWA change **in viral load by NP swab** from Day 1-7

Outcome by Day 28	RDV, n/N (%)	PBO, n/N (%)	RR, %	HR (95% CI)	*P* Value
COVID-19–related hospitalization	2/279 (0.7)	15/283 (5.3)	87	0.13 (0.03-0.59)	.008
COVID-19–related medically attended visits	4/246 (1.6)	21/252 (8.3)	81	0.19 (0.07-0.56)	.002

- No deaths occurred in either arm by Day 28
- FDA approval updated to include nonhospitalized adult and adolescents and EUA extended to include nonhospitalized patients <12 yr old who are at high risk of disease progression

Gottlieb. NEJM. 2022;386:305.

Slide credit: clinicaloptions.com

MOVe-OUT: Final Analysis in Nonhospitalized Adults

- In **nonhospitalized**, at-risk patients with mild to moderate COVID-19, molnupiravir 800 mg every 12 hr for 5 days **reduced risk of hospitalization or death by 30%** (*P* = .0218)

Outcome	Molnupiravir 800 mg Q12H (n = 709)	Placebo (n = 699)
Hospitalization or death, n (%)	48 (6.8)	68 (9.7)
Deaths, n	1	9

- AE profile consistent with the AE profile in the Day 29 interim analysis

- These additional data were presented to FDA's Antimicrobial Advisory Committee, and committee voted 13-10 that the known benefits outweigh potential risks
- EUA for nonhospitalized patients issued by the FDA on December 23, 2021, for use **when alternative COVID-19 treatment options authorized by FDA are *not* accessible or clinically appropriate**

Bernal. NEJM. 2022;386:509-20. Merck press release. November 30, 2021. Data not peer reviewed.
fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-additional-oral-antiviral-treatment-covid-19-certain

Molnupiravir: Assessment and Counseling in Setting of Childbearing Potential

- Assess women for pregnancy
- Either
  - Report of LMP in an individual who has regular menstrual cycles, uses a reliable method of contraception correctly, and/or consistently has had a negative pregnancy test
  - Negative pregnancy test (recommended but not required if other criteria are not met)

- Reliable, correct, and consistent **contraception** required both for **men and women**

♀ – **Women:** during treatment and for **4 days after the last dose** of molnupiravir

♂ – **Men:** during treatment and for **at least 3 mo after the last dose** of molnupiravir

Pregnant recipients should join surveillance registry:
1-877-888-4231 or pregnancyreporting.msd.com

- Includes partners of men who took molnupiravir

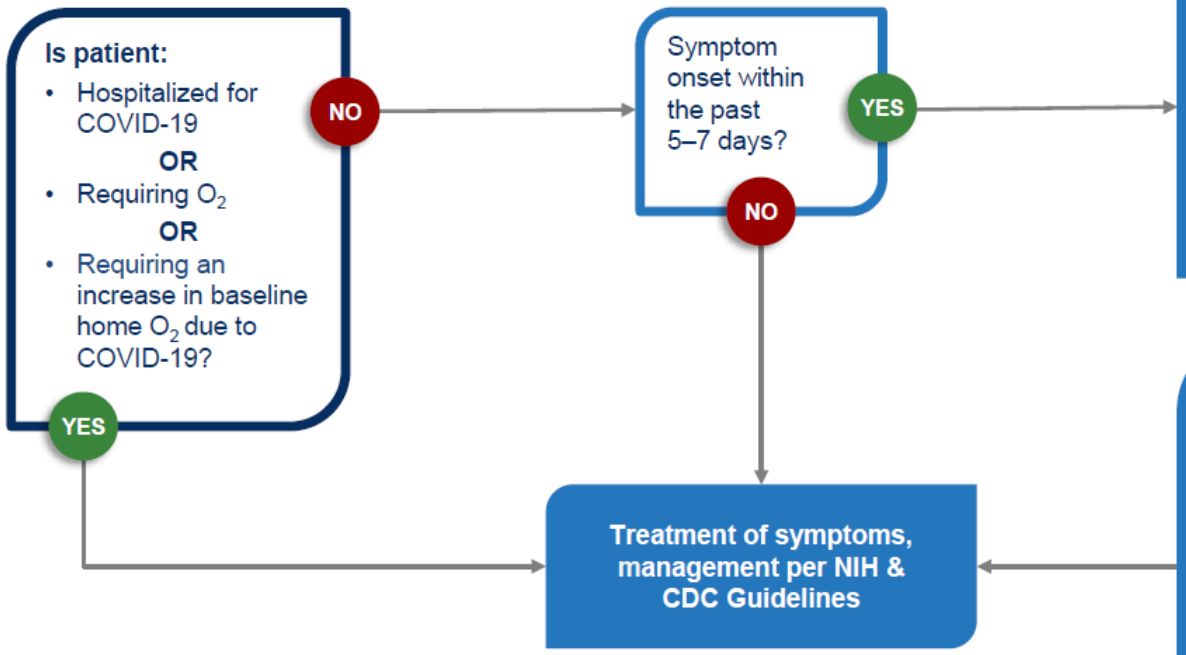
fda.gov/media/155118/download.

Slide credit: clinicaloptions.com

COVID-19 Outpatient Therapeutics

Clinical Decision Aid for Ages 12+

Adult or pediatric patient (ages 12 and older weighing at least 40 kg) with mild to moderate COVID-19 and at high risk for progression to severe disease



Consider one of the following therapeutics, if available, feasible, and clinically appropriate[1]:

Paxlovid[2] within 5 days of symptom onset If patient does not have severe renal impairment (eGFR <30mL/min OR severe hepatic impairment (Child-Pugh Class C)

- **eGFR ≥ 60 mL/min:** 300 mg nirmatrelvir taken with 100 mg ritonavir twice daily for 5 days
- **eGFR ≥ 30 to < 60:** 150 mg nirmatrelvir taken together with 100 mg ritonavir twice daily for 5 days
- Evaluate concomitant use of CYP3A inducers and medications with high dependency on CYP3A for clearance as these may be contraindicated[2,3]

OR

Veklury (remdesivir)[4] 200 mg IV x 1 dose on Day 1, 100 mg IV x 1 on Days 2–3 begun **ASAP within 7 days of symptom onset**

If Paxlovid and Veklury (remdesivir) are not available, feasible or clinically appropriate consider one of the following therapeutics:

bebtelovimab[5] ASAP within 7 days of symptom onset
175 mg single IV injection

OR

Lagevrio (molnupiravir)[6] If patient age 18 or older AND possibility of pregnancy, if applicable, ruled out:

800 mg by mouth every 12h for 5 days begun
ASAP within 5 days of symptom onset

Prescribers must review and comply with the mandatory requirements outlined in the **Lagevrio (molnupiravir) EUA[6]**

References:

[1] NIH's COVID-19 Treatment Guidelines Therapeutic Management of Nonhospitalized Adults With COVID-19. https://www.covid19treatmentguidelines.nih.gov/therapies/statement-on-therapies-for-high-risk-nonhospitalized-patients/
[2] Paxlovid EUA. https://www.fda.gov/media/155050/download
[3] NIH's COVID-19 Treatment Guidelines Panel: Ritonavir-Boosted Nirmatrelvir (Paxlovid). https://www.covid19treatmentguidelines.nih.gov/therapies/antiviral-therapy/ritonavir-boosted-nirmatrelvir--paxlovid-/
[4] Veklury (remdesivir) Prescribing Information. https://www.gilead.com/-/media/files/pdfs/medicines/covid-19/veklury/veklury_pi.pdf
[5] Bebtelovimab EUA. https://www.fda.gov/media/156152/download
[6] Lagevrio EUA. https://www.fda.gov/media/155054/download

NIH Panel Patient Prioritization for Outpatient Anti–SARS-CoV-2 Therapies When There Are Logistical or Supply Constraints

Tier	Priority Population
1	Immunocompromised individuals not expected to mount an adequate immune response to COVID-19 vaccination or SARS-CoV-2 infection due to their underlying conditions, regardless of vaccine status Unvaccinated individuals at the highest risk of severe disease (anyone aged ≥75 yr or anyone aged ≥65 yr with additional risk factors)
2	Unvaccinated individuals at risk of severe disease not included in Tier 1 (anyone aged ≥65 yr or anyone aged <65 yr with clinical risk factors)
3	Vaccinated individuals at high risk of severe disease (anyone aged ≥75 yr or anyone aged ≥65 yr with clinical risk factors)
4	Vaccinated individuals at risk of severe disease (anyone ≥65 yr or anyone <65 yr with clinical risk factors)

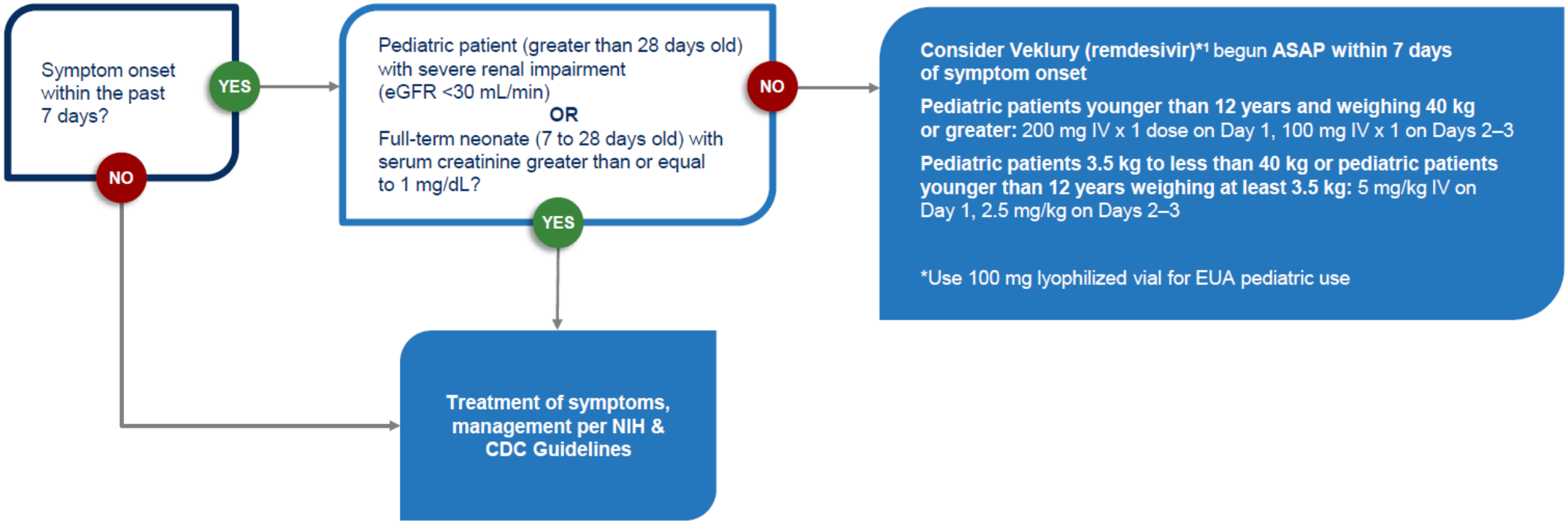
- Individuals in tiers 3 and 4 who have not received a COVID-19 vaccine booster dose are likely at higher risk for severe disease and should be prioritized for treatment

covid19treatmentguidelines.nih.gov/therapies/statement-on-patient-prioritization-for-outpatient-therapies/

Slide credit: clinicaloptions.com

Clinical Decision Aid for Pediatric Patients

Outpatient **3.5 kg to less than 40 kg** or **younger than 12 years of age weighing at least 3.5 kg**, with mild to moderate COVID-19 and at high risk for progression to severe disease



Reference:

[1] Veklury (remdesivir) EUA: https://www.fda.gov/media/137566/download.

ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

Access

Clinicians from outside of Virtua are directed to call 856-325-3150

Patients calling directly for information can be directed to call the access center at 1 888 VIRTUA 3

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Treatment Links

- Below are links to updated treatment guidelines and recommendations:

- https://aspr.hhs.gov/COVID-19/Therapeutics/Documents/COVID-Therapeutics-Decision-Aid.pdf

- https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management/

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Questions?

Thank You