COVID-19 Treatment Center Provider Referral & Prescription for Remdesivir
Greater Lawrence Family Health Center
25 Marston St, Lawrence, MA, Suite 101
Phone: 978-722-2870

Name: _____ **Date of Birth**: _____ **Sex**: _____
Address: _____
Phone: **Cell**) _____ **Home**) _____
Allergies:_____ **Weight**: _____

Fully Vaccinated (>2 weeks since receiving 2nd dose of Pfizer/Moderna or 1st of J&J): **YES** **NO**
Are you a patient of GLFHC or do you live, work, or go to school in Massachusetts: **YES** **NO**

Step 1. Eligibility

☐ **Why does patient not qualify for Paxlovid?**_____
☐ **Date of symptom onset**: _____
☐ **Date of Positive COVID-19 PCR or Antigen Test**:_____
☐ **eGFR and date**_____

Step 2. Prescription

☐ **REMDESIVIR INFUSION *GFR >30***: (**wt≥40kg**) administer 200mg IV Day 1, 100mg IV day 2, 100mg IV day 3. Each infusion to run over 30-120 minutes. No refills. Must be give within 7 days of symptom onset. Reference: **REMDESIVIR INFO.**

☐ **REMDESIVIR INFUSION GFR >30**: (**wt<40kg**) administer ___ mg IV (5mg/kg) Day 1, ___mg IV (2.5mg/kg) day 2, ___ mg IV (2.5mg/kg) day 3. Each infusion to run over 30-120 minutes. No refills. Must be give within 7 days of symptom onset. Reference: **REMDESIVIR INFO.**

Provider attestation:

I have reviewed the medical guidance of options for outpatient treatment of mild-moderate COVID 19 as per Massachusetts DPH guidance. I have reviewed indications and contraindications for, complications of, potential medication interactions, and side effects of the selected treatment and/or medication(s) and have counseled the patient fully on risks and benefits accordingly. Where applicable, I have counseled the referred patient on contraception and pregnancy concerns.

Provider Name (print): _____**Contact Number:** _____
Provider
Address_____

Provider EMAIL: _____

Provider Signature/Title (MD/DO/NP/PA/CNM): _____**Date:** _____

STEP 3. SUBMIT:
FAX this form to 978-722-3077