PAXLOVID ORDER FORM

***** Medication is on Emergency Use Authorization (EUA) *****

Patient Name: _____ DOB: _____

Patient Address: _____

_____

I authorize the following to be given based on medication availability:

☐ **For patients with a GFR ≥ 60 ml/min**
Paxlovid: Nirmatrelvir 300 mg (two 150 mg tablets) with Ritonavir 100 mg (one 100 mg tablet) taken together by mouth twice daily x 5 days.

☐ **For patients with a GFR between 30 to 59 ml/min**
Paxlovid: Nirmatrelvir 150 mg (one 150 mg tablet) with Ritonavir 100 mg (one 100 mg tablet) taken together by mouth twice daily x 5 days.

Provider Name (Print): _____ Date: _____

Provider Address: _____

_____

Provider Phone Number: _____

License: _____

Provider Signature: _____

***** Paxlovid is only authorized for adult or pediatric patients who must be at least 12 years of age and weigh at least 40 kg. The patient must have a Positive SARS-CoV-2 test result (either PCR or antigen testing is accepted) and symptom onset within the last 5 days. If the symptoms have been present for greater than 5 days and ≤ 7 days, or the patient has chronic renal failure with a GFR ≤ 30 ml/min, or the patient's current medications are not compatible with Paxlovid, please consider referring the patient for monoclonal antibody therapy.*****