TOWNCREST PHARMACY
2306 Muscatine Avenue, Iowa City IA 52240

Paxlovid Order Form

Patient Name:____ **DOB:** ___________________________

Address: ____

Phone #: (____) _____ -__________ **Sex:** M / F / Prefer not to answer

Response	Inclusion Criteria (All must apply)
❑ Yes ❑ No	Authorized for use under an EUA for treatment of mild to moderate COVID-19 in adults and pediatricpatients with **positive results of direct SARS-CoV-2 viral testing who are 12 years of age** ***Date of symptom onset: ____________ (Must be filled in to ensure dispensed within 5 days of onset)**
❑ Yes ❑ No	**Symptomatic from SARS-CoV-2 ≤ 5 days** of direct SARS-CoV-2 viral testing
❑ Yes ❑ No	Are at **high risk** for progressing to severe COVID-19 and/or hospitalization. (**must meet 1 or more; select from below**)
❑ Yes ❑ No	Patient eGFR ≥ 30 mL
❑ Yes ❑ No	Patient weight ≥ 40 kg
❑ Yes ❑ No	Patient is not hospitalized due to COVID-19.
❑ Yes ❑ No	Alternative COVID-19 treatment options authorized by the FDA are not accessible or clinically appropriate

High Risk Criteria

❑ Yes ❑ No Older age (for example age ≥65 years of age)

❑ Yes ❑ No Obesity or being overweight (for example, adults with BMI >25 kg/m2, or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)

❑ Yes ❑ No Chronic kidney disease

❑ Yes ❑ No Pregnant/Breast feeding

❑ Yes ❑ No Diabetes

❑ Yes ❑ No Immunosuppressive disease or immunosuppressive treatment

❑ Yes ❑ No Cardiovascular disease (including congenital heart disease) or hypertension

❑ Yes ❑ No Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)

❑ Yes ❑ No Sickle cell disease

❑ Yes ❑ No Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medicalcomplexity (for example, genetic or metabolic syndromes and severe congenital anomalies)

❑ Yes ❑ No Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19))

Molnupiravir Order

❑ eGFR ≥ **60mL**	**Paxlovid: 300mg nirmatrelvir (#2 150mg tablets) with 100mg ritonavir (#1 100mg tablet) ORALLY twice daily for 5 days** Dispense 1 pack with 0 refills	❑ eGFR **30-60**	**Paxlovid: 150mg nirmatrelvir (#1 150mg tablet) with 100mg ritonavir (#1 100mg tablet) ORALLY twice daily for 5 days** Dispense 1 pack (with modifications) with 0 refills

Prescriber Name/Signature: ______________________________ Date: __________

Address: ______________________________ NPI: __________