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Select entries were updated on 5/28/2020; these can be identified by the date that appears in the Drug(s) column.

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Updated 5-28-20. The current version of this document can be found on the [ASHP COVID-19 Resource Center](https://www.ashp.org).
## ANTIVIRAL AGENTS

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| Baloxavir        | 8:18.92    | Antiviral active against influenza viruses                                 | Only limited clinical trial data available to date to evaluate use of baloxavir for treatment of COVID-19  
Exploratory, open-label, randomized controlled study at a single center in China (ChiCTR2000029544): 29 adults hospitalized with COVID-19 receiving antiviral treatment with lopinavir/ritonavir, darunavir/cobicistat, or umifenovir (Arbidol\(^\text{®}\)), in combination with inhaled interferon-\(\alpha\), were randomized to treatment with baloxavir marboxil (80 mg orally on day 1 and on day 4, and 80 mg orally on day 7 as needed) (n=10), favipiravir (1600 or 2200 mg orally on day 1, followed by 600 mg three times daily for up to 14 days) (n=9), or control (standard antiviral treatment) (n=10). Percentage of pts with viral conversion (2 consecutive tests with undetectable viral RNA results) after 14 days of treatment was 70, 77, and 100% in the baloxavir, favipiravir, and control groups, respectively, with median time to clinical improvement of 14, 14, and 15 days, respectively.  
Another randomized controlled trial registered in China: \(^1\)CHICTR2000029548  
Protocol for two registered Chinese trials (ChiCTR2000029544, CHICTR2000029548) specifies an oral baloxavir marboxil dosage of 80 mg on day 1 and on day 4, and another dose of 80 mg on day 7 (as needed); not to exceed 3 total doses. \(^1, 3\)  
No data to date support use in the treatment of COVID-19 | Updated 5/13/20 |                                                                     |
| Chloroquine Phosphate | 8:30.08    | In vitro activity against various viruses, including coronaviruses  
In vitro activity against SARS-CoV-2 in infected Vero E6 cells reported; some evidence it may block infection in Vero E6 cells exposed to SARS-CoV-2  
Active in vitro against SARS-CoV-1 and MERS-CoV  
Has immunomodulatory activity that theoretically could contribute to an  
Efficacy and safety of chloroquine for treatment or prevention of COVID-19 not established \(^10, 24, 39\)  
Additional data needed to determine whether in vitro activity against SARS-CoV-2 corresponds with clinical efficacy for treatment or prevention of COVID-19  
Data from randomized, controlled clinical trials needed to substantiate initial reports of efficacy of 4-aminoquinoline antimalarials for treatment of COVID-19, guide decisions regarding the most appropriate pts for treatment with such drugs, and identify optimal dose and treatment duration | Updating 5/28/20 | Only limited clinical trial data available to date to evaluate use of chloroquine for treatment or prevention of COVID-19  
Clinical experience in treating pts with COVID-19 accumulating; some reports of possible clinical benefits, including decrease in viral load and duration of illness; \(^4-6\) majority of data to date involves use in pts with mild or moderate COVID-19; \(^5\) only limited clinical data on use in pts with severe disease.  
Small, randomized study in hospitalized adults in China compared chloroquine with LPV/RTV (Huang et al): 10 pts (7 with moderate and 3 with severe COVID-19) received chloroquine (500 mg twice daily | Optimal dosage and duration of treatment not known \(^25\)  
Consider: 500 mg of chloroquine phosphate is equivalent to 300 mg of chloroquine base \(^17\)  
Various dosages recommended or being investigated for treatment of COVID-19  
Oral chloroquine phosphate dosage suggested by the EUA: For treatment of hospitalized adults and adolescents weighing 50 kg or more when a clinical trial is not available or participation not feasible, 1 g on day 1, then 500 mg twice daily for 4-7 days of |
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<td>anti-inflammatory response in patients with viral infections 1-3, 13, 15-16</td>
<td>for 10 days) and 12 pts (7 with moderate and 5 with severe COVID-19) received LPV/RTV (lopinavir 400 mg/ritonavir 100 mg twice daily for 10 days). All 10 pts treated with chloroquine had negative RT-PCR results for SARS-CoV-2 by day 13 and were discharged from the hospital by day 14; 11/12 pts (92%) treated with LPV/RTV were negative for SARS-CoV-2 at day 14 and only 6/12 (50%) were discharged from the hospital by day 14. <strong>Note:</strong> Results suggest that chloroquine was associated with shorter time to RT-PCR conversion and quicker recovery than LPV/RTV; however, this study included a limited number of pts and the median time from onset of symptoms to initiation of treatment was shorter in those treated with chloroquine than in those treated with LPV/RTV (2.5 vs 6.5 days, respectively). 20</td>
<td>Total treatment based on clinical evaluation 25</td>
<td>Additional data needed regarding toxicity profile when used in patients with COVID-19</td>
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<td>Known pharmacokinetics and toxicity profile based on use for other indications 11, 17</td>
<td>Double-blind randomized phase 2b study in Brazil, (Borba et al) to evaluate two different chloroquine dosages as adjunctive therapy in hospitalized adults with severe COVID-19 (NCT04323527): The first 81 enrolled pts were randomized 1:1 to receive high-dose chloroquine (600 mg twice daily for 10 days) or lower-dose chloroquine (450 mg twice daily on day 1, then 450 mg once daily on days 2-5); all pts also received azithromycin and ceftriaxone and some also received oseltamivir. An unplanned interim analysis was performed and the high-dose arm of the study was halted because of toxicity concerns, particularly QTc prolongation and ventricular tachycardia, and because more deaths were reported in this arm. By day 13, 16/41 pts (39%) treated with the high-dose regimen had died vs 6/40 (15%) treated with the lower-dose regimen. QT, &gt;500 msec occurred more frequently in the high-dose group (18.9%) than in the lower-dose group (11.1%). The high-dose arm included more pts prone to cardiac complications than the lower-dose arm. Data were insufficient to evaluate efficacy. Study continuing using only the lower dosage. 27</td>
<td>Oral chloroquine phosphate dosage in Chinese guidelines: 500 mg twice daily for 7 days (adults 18-65 years weighing &gt;50 kg); 500 mg twice daily on days 1 and 2, then 500 mg once daily on days 3-7 (adults weighing &lt;50 kg) 11</td>
<td>Chloroquine suggested as possible option and included in Chinese guidelines for treatment of COVID-19. 34</td>
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<td>NIH COVID-19 Treatment Guidelines Panel states that clinical data are insufficient to recommend either for or against the use of chloroquine for the treatment of COVID-19; the panel recommends against use of high-dose chloroquine (i.e., 600 mg twice daily for 10 days) because such dosage has been associated with more severe toxicities compared with lower-dose chloroquine. 35</td>
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<td>IDSA recommends that chloroquine be used for the treatment of COVID-19 in the context of a clinical trial. 38 IDSA recommends that a combined regimen of chloroquine and azithromycin be used for the treatment of COVID-19 only in the context of a clinical trial. 35</td>
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<td>NIH COVID-19 Treatment Guidelines Panel does not recommend the use of any agents, including chloroquine, for preexposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for prevention of SARS-CoV-2 infection outside of clinical trials. 35</td>
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<td>Because chloroquine is associated with QT prolongation, caution is advised in pts at risk for QT prolongation or receiving other drugs associated with arrhythmias. 11, 17, 36, 39 Diagnostic testing and monitoring recommended to minimize risk of adverse effects, including drug-induced cardiac effects. 35, 36, 39 (See Hydroxychloroquine in this Evidence Table.)</td>
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<td>FDA issued a safety alert regarding adverse cardiac effects (e.g., prolonged QT interval, ventricular tachycardia,</td>
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1. Updated 5-28-20. The current version of this document can be found on the ASHP COVID-19 Resource Center.
2. This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.
3. Toxicity profile based on use for other indications.
4. May be used off-label for treatment of COVID-19 in the context of a clinical trial.
6. May be used off-label for treatment of COVID-19 in the context of a clinical trial.
7. Hydroxychloroquine in this Evidence Table.
8. See Hydroxychloroquine in this Evidence Table.
9. See Hydroxychloroquine in this Evidence Table.
10. See Hydroxychloroquine in this Evidence Table.
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<td>Favi...</td>
<td>Antiviral</td>
<td>Broad-s...</td>
<td>Only very limited clinical tri...</td>
<td>A fav...</td>
<td>Not comm...</td>
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Favipiravir (Avigan®, Favilavir)  

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| pts with confirmed COVID-19 to assess the effects of chloroquine or hydroxychloroquine used with or without a macrolide (Mehra et al): Results indicate that treatment with one of these 4-aminoquinoline antimalarials with or without a macrolide (azithromycin or clarithromycin) was independently associated with an increased risk of in-hospital mortality and was independently associated with an increased risk of de-novo ventricular arrhythmia during hospitalization. 50 (See Hydroxychloroquine in this Evidence Table.)  

Multiple clinical trials to evaluate chloroquine for the treatment of COVID-19 are registered at clinicaltrials.gov (some listed below): 10  
NCT04323527  
NCT04328493  
NCT04331600  
NCT04333628  
NCT04353336  
NCT04360759  
NCT04362332  
Several clinical trials to evaluate chloroquine for prevention of COVID-19 in the healthcare setting are registered at clinicaltrials.gov: 10  
NCT04303507  
NCT04333732  
NCT04349371  

Emergency use authorization (EUA) for chloroquine: FDA issued an EUA that permits distribution of the drug from the strategic national stockpile (SNS) for use only in adults and adolescents weighing 50 kg or more hospitalized with COVID-19 for whom a clinical trial is not available or participation not feasible. 24, 25 To request the drug, healthcare providers should contact local or state health departments; 25 distribution to states will be managed by the Office of the Assistant Secretary for Preparedness and Response (ASPR) and FEMA. 29 To mitigate risks of this unapproved use, the EUA includes certain mandatory requirements (including adverse event reporting to FDA MedWatch). 24, 25 FDA states that, based on the totality of scientific evidence available, it is reasonable to believe that the drug may be effective in treating COVID-19 and that, when used under the EUA conditions, known and potential benefits outweigh known and potential risks. 24 Consult the EUA, 24 EUA fact sheet for healthcare providers, 25 and EUA fact sheet for patients and parent/caregivers 27 for additional information.  

A favipiravir dosage of 1600 mg twice daily on day 1, then 600 mg twice daily thereafter for 7–10 days was used in one open-label COVID-19 study 6  
A favipiravir dosage of 1600 mg twice daily on day 1, then 600 mg twice weekly ventricular fibrillation) reported with use of chloroquine or hydroxychloroquine (either alone or in conjunction with azithromycin or other drugs known to prolong QT interval) in hospital and outpatient settings; FDA cautions against use of chloroquine or hydroxychloroquine outside of a clinical trial or hospital setting and urges healthcare professionals and pts to report adverse effects involving these drugs to FDA MedWatch. 39  

Not commercially available in the US  
Efficacy and safety of favipiravir for treatment of COVID-19 not established  
Additional data needed to substantiate initial reports of efficacy for treatment
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<td>Favipiravir</td>
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<td>reported with high concentrations of the drug 5, 6, 16</td>
<td>daily thereafter for 14 days was used in one open-label COVID-19 study 15</td>
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<td>Licensed in Japan and China for treatment of influenza 4, 6</td>
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<td>orally twice daily on day 1, then 600 mg orally twice daily thereafter for 7–10 days</td>
<td>Protocol in one ongoing trial (NCT04336904) for treatment of moderate COVID-19 specifies a favipiravir dosage of 1800 mg twice daily on day 1, then 600 mg three times daily thereafter for up to 14 days 7</td>
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<td>was associated with greater clinical recovery rate at 7 days (61 vs 52%) compared with the control group treated with umifenovir (Arbidol®; 200 mg 3 times daily for 7–10 days). Stratified by disease severity, clinical recovery rate at day 7 in pts with moderate COVID-19 pneumonia was 71% in the favipiravir group vs 56% in the umifenovir group; clinical recovery rate in those with severe to critical COVID-19 pneumonia was 6% vs 0%, respectively. Twice as many pts in the favipiravir group had severe to critical disease compared with the group receiving umifenovir. 6</td>
<td>Protocol in one ongoing trial (NCT04346628) for treatment of mild COVID-19 specifies a favipiravir dosage of 1800 mg on day 1, then 800 mg twice daily on days 2–10 7</td>
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<td>Protocol in one ongoing trial (NCT04349241) for treatment of non-severe COVID-19 specifies a favipiravir dosage of 1600 mg every 12 hours on day 1, then 600 mg every 12 hours on days 2–10 7</td>
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<td>Protocol in one ongoing trial NCT04358549 for treatment of COVID-19 specifies a favipiravir dosage of 1800 mg twice daily on day 1, then 1000 mg twice daily on days 2–14 7</td>
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<td>Protocol in one ongoing trial (NCT04373733; PIONEER) for early treatment of suspected or confirmed COVID-19 specified a favipiravir dosage of 1800 mg twice daily on day 1, followed by 800 mg twice daily on days 2–10 7</td>
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<td>Because high favipiravir concentrations are required for in vitro activity against SARS-CoV-2, 1, 5, 11 it has been suggested that high favipiravir dosages, like those used in the treatment of Ebola virus disease, should be considered for the treatment of COVID-19. 11, 19, 20</td>
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<td>One such favipiravir regimen used in the treatment of Ebola virus disease includes a loading dosage of 6000 mg (doses of 2400 mg, 2400 mg, and 1200 mg given 8 hours apart on day 1), then a maintenance dosage of 1200 mg</td>
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In a small, open-label, nonrandomized study 7 in patients with non-severe COVID-19 in China (ChiCTR2000029600), favipiravir (1600 mg orally twice daily on day 1, then 600 mg orally twice daily on days 2–14) (n=35) was associated with decreased median time to viral clearance (4 vs 11 days) and higher improvement rate on chest CT imaging on day 14 (91 vs 62%) compared with the control group receiving lopinavir/ritonavir (n=45); both groups also received aerosolized interferon α-1b. 15

**US:** Randomized, controlled open-label proof-of-concept trial (NCT04358549) of favipiravir for the treatment of COVID-19 7

**US:** Randomized, open-label trial (NCT04346628) to evaluate efficacy of favipiravir in pts with mild, uncomplicated COVID-19 7

**Multiple clinical trials initiated** in pts with COVID-19 in China, Japan, and other countries to evaluate favipiravir alone or in conjunction with other antivirals or other agents (some listed below): 7, 9

NCT04310228

NCT04319900

Early embryonic deaths and teratogenicity observed in animal studies. Favipiravir is contraindicated in women with known or suspected pregnancy and precautions should be taken to avoid pregnancy during treatment with the drug. 14

If favipiravir is used in pts receiving acetaminophen, the maximum recommended daily dosage of acetaminophen is 3 g 17, 18

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| HIV Protease Inhibitors             | 8:18.08.08 | HIV Protease Inhibitors                                                                      | Lopinavir (LPV): In vitro activity against SARS-CoV-2 in Vero E6 cells; also has in vitro activity against SARS-CoV-1 and MERS-CoV; some evidence of benefit in animal studies for treatment of MERS-CoV | every 12 hours on days 2–10. One pharmacokinetic simulation model suggested that a dosage of 2400 mg twice daily on day 1, followed by 1600 mg twice daily on days 2–10 should achieve adequate faviptiravir trough plasma concentrations and may be more pharmacologically relevant | HIV Protease Inhibitors

Lopinavir and Ritonavir (LPV/RTV; Kaletra®) randomized, open-label trial in China (Cao et al) in hospitalized adults with severe COVID-19 compared LPV/RTV in conjunction with standard care (99 pts) vs standard care alone (100 pts). Primary end point was time to clinical improvement (time from randomization to improvement of two points on a seven-category ordinal scale or hospital discharge, whichever came first). In ITT population, time to clinical improvement was not shorter with LPV/RTV compared with standard care (median time to clinical improvement 16 days in both groups); in modified ITT population, median time to clinical improvement 15 days in LPV/RTV group and 16 days in standard care only group. The 28-day mortality rate was numerically lower in LPV/RTV group (19.2% vs 25% in ITT population; 16.7% vs 25% in modified ITT population). Some evidence that LPV/RTV initiation within 12 days after symptom onset is associated with shorter time to clinical improvement. No significant differences in reduction of viral RNA load, duration of viral RNA detectability, duration of oxygen therapy, duration of hospitalization, or time from randomization to death. LPV/RTV stopped early in 13 pts because of adverse effects. |
<p>|                                      |            | Atazanavir (ATV): ATV alone or with ritonavir (ATV/RTV) has in vitro activity against SARS-CoV-2 in Vero E6 cells, human epithelial pulmonary cells (A549), and human monocytes |
|                                      |            | Darunavir (DRV): In one study, DRV with cobicistat had no in vitro activity against SARS-CoV-2 at clinically relevant concentrations in Caco-2 cells; in another study, high DRV concentrations were required for in vitro inhibition of SARS-CoV-2 in Vero E6 cells |
|                                      |            | Nelfinavir (NFV), Saquinavir (SQV), and Tipranavir (TPV): In vitro activity against SARS-CoV-2 in Vero E6 cells |
|                                      |            | LPV/RTV (COVID-19): LPV 400 mg/RTV 100 mg orally twice daily for 10-14 days |
|                                      |            | LPV/RTV (COVID-19): LPV 400 mg/RTV 100 mg orally twice daily with or without umifenovir (Arbidol® 200 mg every 8 hours) |
|                                      |            | LPV/RTV (COVID-19): LPV 400 mg/RTV 100 mg orally twice daily for no longer than 10 days with or without interferon (5 million units of interferon-α or equivalent twice daily given in 2 mL of sterile water by nebulization) and with or without ribavirin for up to 10 days |
|                                      |            | LPV/RTV (COVID-19): LPV 400 mg/RTV 100 mg orally twice daily with or without other antivirals, not definitely established |
|                                      |            | Darunavir: No data to date to support use in the treatment of COVID-19. Manufacturer states they have no clinical or pharmacologic evidence to support use of DRV/cobicistat for treatment of COVID-19 and initial unpublished results from a study in China indicated that a 5-day regimen of DRV/cobicistat was not effective for treatment of COVID-19 |
|                                      |            | Atazanavir, Nelfinavir, Saquinavir, Tipranavir: No data to date to support use in the treatment of COVID-19 |
|                                      |            | NIH COVID-19 Treatment Guidelines Panel recommends against the use of LPV/RTV or other HIV protease inhibitors for the treatment of COVID-19, except in the context of a clinical trial |
|                                      |            | IDSA recommends that LPV/RTV be used for the treatment of COVID-19 only in the context of a clinical trial |
|                                      |            | Updated 5/21/20. The current version of this document can be found on the ASHP COVID-19 Resource Center. | This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License |</p>
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<td>LPV/RTV ± chloroquine in small, randomized study in hospitalized adults with COVID-19 in China (Huang et al):</td>
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<td>10 pts (7 with moderate and 3 with severe disease) received chloroquine (500 mg twice daily for 10 days) and 12 pts (7 with moderate and 5 with severe disease) received LPV/RTV (lopinavir 400 mg/ritonavir 100 mg twice daily for 10 days). All 10 pts treated with chloroquine had negative RT-PCR results for SARS-CoV-2 by day 13 and were discharged from the hospital by day 14; 11/12 pts (92%) treated with LPV/RTV were negative for SARS-CoV-2 at day 14 and only 6/12 (50%) were discharged from the hospital by day 14. <strong>Note:</strong> Results suggest that chloroquine was associated with shorter time to RT-PCR conversion and quicker recovery than LPV/RTV; however, this study included a limited number of pts and the median time from onset of symptoms to initiation of treatment was shorter in those treated with chloroquine than in those treated with LPV/RTV (2.5 vs 6.5 days, respectively).</td>
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<td>LPV/RTV ± ribavirin and interferon β-1b vs LPV/RTV alone in open-label, randomized trial in adults with mild to moderate COVID-19 in Hong Kong (Hung et al; NCT04276688):</td>
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<td>127 pts were randomized 2:1 to receive LPV/RTV (LPV 400 mg/RTV 100 mg) twice daily for 14 days) with ribavirin (400 mg twice daily) and interferon β-1b (8 million IU sub-Q on alternate days for up to 3 doses depending on how soon treatment initiated after symptom onset) or a 14-day regimen of LPV/RTV alone. Median time to negative RT-PCR results for SARS-CoV-2 in nasopharyngeal samples was 7 days in pts treated with the 3-drug regimen vs 12 days in those treated with LPV/RTV alone; median duration of hospitalization was 9 or 14.5 days, respectively. Adverse effects reported in 48% of those treated with the 3-drug regimen and in 49% of those treated with LPV/RTV alone. <strong>Note:</strong> Results indicate a 3-drug regimen that included LPV/RTV, ribavirin, and interferon β-1b was more effective than LPV/RTV alone in pts with mild to moderate COVID-19, especially when treatment was initiated within 7 days of symptom onset.</td>
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<td>Hydroxychloroquine (Plaquenil®)</td>
<td>8:30.08 Antimalarial (4-aminoquino-line derivative)</td>
<td>In vitro activity against various viruses, including coronaviruses In vitro activity against SARS-CoV-2 in infected</td>
<td><strong>Only limited clinical trial data available</strong> to date to evaluate use of hydroxychloroquine for treatment or prevention of COVID-19 <strong>Clinical experience</strong> in treating pts with COVID-19 accumulating; majority of data Efficacy and safety of hydroxychloroquine for treatment or prevention of COVID-19 not established Additional data needed to determine whether in vitro activity against...</td>
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<tr>
<td>Hydroxychloroquine sulfate</td>
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<td>SARS-CoV-2 corresponds with clinical efficacy for treatment or prevention of COVID-19.</td>
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<td>Hydroxychloroquine</td>
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<td>(54.8%) in control group. Total of 4 pts progressed to severe illness (all in the control group). 31 <strong>Note:</strong> This study did not include pts with severe disease and pts received other anti-infectives in addition to hydroxychloroquine. At study entry, 9 pts without fever and 9 pts without cough were included in hydroxychloroquine group and 14 pts without fever and 16 pts without cough were included in control group; unclear how these pts were addressed in TTSCR calculations. Although initial registered study protocol specified 2 different hydroxychloroquine treatment groups and a placebo group (each with 100 pts) and primary end points of time to negative nucleic acid and T-cell recovery, 32 data provided only for certain clinical symptoms in 62 pts without severe disease and PCR results not reported. 31</td>
<td>(PreP) or postexposure prophylaxis (PEP) for prevention of SARS-CoV-2 infection outside of clinical trials. 35 Because hydroxychloroquine is associated with QT prolongation and because use of hydroxychloroquine with azithromycin may further increase the risk of QT prolongation, caution is advised when considering use of hydroxychloroquine (with or without azithromycin) in pts with COVID-19, especially in outpatients who may not receive close monitoring and in those at risk for QT prolongation or receiving other drugs associated with arrhythmias. 35, 36, 38, 39, 41-44 The benefits and risks of hydroxychloroquine (with or without azithromycin) should be carefully assessed; diagnostic testing and monitoring are recommended to minimize risk of adverse effects, including drug-induced cardiac effects. 35, 36, 38, 39, 41-44 FDA issued a safety alert regarding adverse cardiac effects (e.g., prolonged QT interval, ventricular tachycardia, ventricular fibrillation) reported with use of chloroquine or hydroxychloroquine (either alone or in conjunction with azithromycin or other drugs known to prolong QT interval) in hospital and outpatient settings; FDA cautions against use of chloroquine or hydroxychloroquine outside of a clinical trial or hospital setting and urges healthcare professionals and pts to report adverse effects involving these drugs to FDA MedWatch. 39</td>
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**Trials or Clinical Experience**

Hydroxychloroquine randomized, parallel-group, open-label study in hospitalized adults with mild to moderate COVID-19 in China (ChiCTR2000029868): 150 pts (148 with mild to moderate disease and 2 with severe disease) were randomized 1:1 to receive hydroxychloroquine (1200 mg daily for 3 days, then 800 mg daily for total treatment duration of 2-3 weeks) with standard of care or standard of care alone. Mean time from onset of symptoms to randomization was 16.6 days (range: 3-41 days). Standard of care included IV fluids, O₂, various antivirals (e.g., umifenovir, LPV/RTV), antibiotics, and/or glucocorticoid therapy. By day 28, 73% of pts (53 treated with hydroxychloroquine with standard of care and 56 treated with standard of care alone) had converted to negative for SARS-CoV-2. The probability of negative conversion by day 28 in those treated with hydroxychloroquine was similar to that in those treated with standard of care alone; the median time to negative seroconversion (6 and 7 days) also was similar in both groups. Adverse effects reported in 30% of those treated with hydroxychloroquine and 9% of those treated with standard of care alone. **Note:** Results indicate that use of hydroxychloroquine in pts with mild to moderate COVID-19 did not provide additional benefits and risks of hydroxychloroquine (with or without azithromycin) in pts with COVID-19, especially in outpatients who may not receive close monitoring and in those at risk for QT prolongation or receiving other drugs associated with arrhythmias. 35, 36, 38, 39, 41-44 The benefits and risks of hydroxychloroquine (with or without azithromycin) should be carefully assessed; diagnostic testing and monitoring are recommended to minimize risk of adverse effects, including drug-induced cardiac effects. 35, 36, 38, 39, 41-44 FDA issued a safety alert regarding adverse cardiac effects (e.g., prolonged QT interval, ventricular tachycardia, ventricular fibrillation) reported with use of chloroquine or hydroxychloroquine (either alone or in conjunction with azithromycin or other drugs known to prolong QT interval) in hospital and outpatient settings; FDA cautions against use of chloroquine or hydroxychloroquine outside of a clinical trial or hospital setting and urges healthcare professionals and pts to report adverse effects involving these drugs to FDA MedWatch. 39 |

<p>| <a href="https://www.nhc.org/ResourceCenter/index.aspx">Resource Center</a> | <a href="https://www.nhc.org/ResourceCenter/clinical.aspx">Clinical Experience</a> | <a href="https://www.nhc.org/ResourceCenter/dosage.aspx">Dosage</a> | <a href="https://www.nhc.org/ResourceCenter/clinical.aspx">Comments</a> | <a href="https://www.nhc.org/ResourceCenter/updated.aspx">Updated</a> | <a href="https://creativecommons.org/licenses/by-nc/4.0/">This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License</a> |</p>
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<td><em>benefits compared with use of standard of care alone.</em> 49</td>
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<td><strong>Hydroxychloroquine with azithromycin</strong>&lt;br&gt;open-label, nonrandomized study in France (Gautret et al): Preliminary data from an ongoing study in hospitalized pts with confirmed COVID-19 was used to assess efficacy of hydroxychloroquine used alone or with azithromycin; untreated pts were used as a negative control. The primary end point was negative PCR results in nasopharyngeal samples at day 6. Data from 14 pts treated with hydroxychloroquine sulfate (200 mg 3 times daily for 10 days), 6 pts treated with hydroxychloroquine and azithromycin (500 mg on day 1, then 250 mg daily on days 2-5), and 16 pts in the control group were analyzed. At day 6, 8/14 (57%) in the hydroxychloroquine group, 6/6 (100%) in the hydroxychloroquine and azithromycin group, and 2/16 (12.5%) in the control group had negative PCR results. At day 8, a positive PCR was reported in a pt treated with both drugs who had tested negative at day 6. 7 <strong>Note:</strong> This was a small nonrandomized study that didn’t appear to be designed to compare hydroxychloroquine vs hydroxychloroquine and azithromycin (pts received antibiotics to prevent bacterial superinfection based on clinical judgment). Data on disease severity were unclear (some asymptomatic pts were included when study initiated) and information on disease progression and clinical outcomes was not presented.</td>
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<td><strong>Hydroxychloroquine with azithromycin</strong>&lt;br&gt;open-label, uncontrolled study in France (Molina et al): 11 adults hospitalized with COVID-19 received hydroxychloroquine (600 mg daily for 10 days) and azithromycin (500 mg on day 1, then 250 mg daily on days 2-5). At time of treatment initiation, 8/11 pts had significant comorbidities associated with poor outcomes and 10/11 had fever and received O₂. Within 5 days, 1 pt died and 2 transferred to ICU; the regimen was discontinued in 1 pt after 4 days because of prolonged QT interval. Nasopharyngeal samples were still PCR positive at days 5 and 6 in 8/10 pts tested. 33 <strong>Note:</strong> In</td>
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<td>this small uncontrolled study, hydroxychloroquine and azithromycin regimen did not result in rapid viral clearance or provide clinical benefit.</td>
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<td>Hydroxychloroquine with azithromycin uncontrolled, retrospective, observational study in France (Gautret et al): 80 adults with confirmed COVID-19 (including 6 pts included in a previous study by the same group) were treated with hydroxychloroquine sulfate (200 mg 3 times daily for 10 days) and azithromycin (500 mg on day 1, then 250 mg daily on days 2-5). Majority (92%) were considered low risk for clinical deterioration (low national early warning score for COVID-19 based on age, respiratory rate, O₂ saturation, temperature, BP, pulse, level of consciousness); only 15% had fever; 4 pts were asymptomatic carriers; mean time from onset of symptoms to treatment initiation was 4.9 days. Clinical outcome, contagiousness as assessed by nasopharyngeal PCR assay and culture, and length of stay in infectious disease (ID) unit were evaluated in pts who were treated for at least 3 days and followed for at least 6 days. Favorable outcome was reported for 81.3%; 15% required O₂; 3 pts transferred to ICU; 1 pt died; mean time to discharge from ID unit was 4.1 days. At day 8, PCR results were negative in 93% of those tested; at day 5, viral cultures were negative in 97.5% of those tested.</td>
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<td>Note: Almost all pts were considered low risk for clinical deterioration (including 4 pts described as asymptomatic carriers) and it is unclear how many would have had spontaneous conversion to negative nasopharyngeal samples during same time frame. Although 80 pts were enrolled, PCR results available for fewer pts beginning on day 3 and only 60 pts represented in day 6 data. This was an uncontrolled study and data presented cannot be used to determine whether a regimen of hydroxychloroquine with azithromycin provides benefits in terms of disease progression or decreased infectiousness, especially for pts with more severe disease.</td>
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*Note: Almost all pts were considered low risk for clinical deterioration (including 4 pts described as asymptomatic carriers) and it is unclear how many would have had spontaneous conversion to negative nasopharyngeal samples during same time frame. Although 80 pts were enrolled, PCR results available for fewer pts beginning on day 3 and only 60 pts represented in day 6 data. This was an uncontrolled study and data presented cannot be used to determine whether a regimen of hydroxychloroquine with azithromycin provides benefits in terms of disease progression or decreased infectiousness, especially for pts with more severe disease.
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<td>Hydroxychloroquine with azithromycin</td>
<td>uncontrolled, observational, retrospective analysis in France (Million et al):</td>
<td>Data for 1061 pts with PCR-documented SARS-CoV-2 RNA who were treated with a regimen of hydroxychloroquine sulfate (200 mg 3 times daily for 10 days) and azithromycin (500 mg on day 1, then 250 mg daily on days 2-5) were analyzed for clinical outcomes and persistence of viral shedding. Pts were included in the analysis if they received the combined regimen for at least 3 days and were clinically assessable at day 9. There were 56 asymptomatic and 1005 symptomatic pts; the majority (95%) had relatively mild disease and were considered low risk for clinical deterioration; median age was 43.6 years (range: 14-95 years) and mean time between onset of symptoms and initiation of treatment was 6.4 days. Within 10 days of treatment, good clinical outcome reported in 973 pts (91.7%) and poor clinical outcome reported in 46 pts (4.3%). Persistent nasal carriage of SARS-CoV-2 reported at completion of treatment in 47 pts (4.4%); 8 pts died.</td>
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| Hydroxychloroquine (with or without azithromycin) | in a retrospective analysis of patients hospitalized with COVID-19 in US Veterans Health Administration medical centers (Magagnoli et al): | Data for 368 males (median age >65 years) treated with hydroxychloroquine in addition to standard supportive management were analyzed for death rate and need for mechanical ventilation. Death rate was 27.8% (27/97) in those treated with hydroxychloroquine, 22.1% (25/113) in those treated with hydroxychloroquine and azithromycin, and 11.4% (18/158) in those not treated with hydroxychloroquine; rate of ventilation was 13.3, 6.9, and 14.1, respectively. Use of hydroxychloroquine alone (but not use of hydroxychloroquine and azithromycin) was associated with increased overall mortality compared with no hydroxychloroquine; use of hydroxychloroquine with or without azithromycin did not reduce the risk of mechanical ventilation. | | | Note: The pt population included only elderly males 59-
75 years of age, many with significant comorbidities. This analysis did not look at efficacy measures.

Two different retrospective studies analyzed outcome data for hospitalized pts with confirmed COVID-19 in New York to assess the effects of treatment with hydroxychloroquine with or without azithromycin: Rosenberg et al analyzed data for 1438 pts (735 received hydroxychloroquine with azithromycin, 271 received hydroxychloroquine alone, 211 received azithromycin alone, 221 received neither drug) and assessed in-hospital mortality (primary outcome). Overall, in-hospital mortality was 20.3%; in-hospital mortality was 25.7, 19.9, 10, or 12.7% in those treated with hydroxychloroquine with azithromycin, hydroxychloroquine alone, azithromycin alone, or neither drug, respectively. Geleris et al analyzed data for 1376 pts (811 received hydroxychloroquine [486 of these also received azithromycin] and 565 did not receive hydroxychloroquine [127 of these received azithromycin]) and assessed the primary end point of time from study baseline to intubation or death. Overall, 346 pts (25.1%) progressed to a primary end point of intubation and/or death and the composite end point of intubation or death was not affected by hydroxychloroquine treatment (intubation or death reported in 32.3% of pts treated with hydroxychloroquine and 14.9% of pts not treated with the drug). Note: Results of both studies suggest that use of hydroxychloroquine with or without azithromycin is not associated with decreased in-hospital mortality.

Large, multinational, retrospective study analyzed outcome data for hospitalized pts with confirmed COVID-19 to assess the effects of hydroxychloroquine or chloroquine used with or without a macrolide (Mehra et al): Data for 96,032 pts hospitalized with COVID-19 between Dec 20, 2019 and Apr 14, 2020 were obtained from 671 hospitals worldwide. There were 14,888 pts who received chloroquine or hydroxychloroquine with or without a...
macrolide (azithromycin or clarithromycin) initiated within 48 hours of diagnosis (treatment group) and 81,144 pts who did not receive these drugs (control group). The primary outcome was in-hospital mortality and the secondary outcome was occurrence of clinically important ventricular arrhythmia during hospitalization. In-hospital mortality rate in the control group was 9.3% compared with 18% in those treated with hydroxychloroquine alone (n=3016), 23.8% in those treated with hydroxychloroquine and a macrolide (n=6221), 16.4% in those treated with chloroquine alone (n=1868), and 22.2% in those treated with chloroquine and a macrolide (n=3783). De-novo ventricular arrhythmia during hospitalization was reported in 0.3% of pts in the control group compared with 6.1% of those treated with hydroxychloroquine alone, 8.1% of those treated with hydroxychloroquine and a macrolide, 4.3% of those treated with chloroquine alone, and 6.5% of those treated with chloroquine and a macrolide. After controlling for multiple confounding factors (e.g., age, sex, race or ethnicity, body-mass index, underlying cardiovascular disease and its risk factors, diabetes, underlying lung disease, smoking, immunosuppression, baseline disease severity), treatment with hydroxychloroquine or chloroquine (with or without a macrolide) was independently associated with an increased risk of in-hospital mortality and was independently associated with an increased risk of de-novo ventricular arrhythmia during hospitalization. There also was evidence that the risk of de-novo ventricular arrhythmia is increased when hydroxychloroquine or chloroquine is used with a macrolide. 50

Efficacy measures: Initial studies evaluating hydroxychloroquine based efficacy of the drug on negative conversion in nasopharyngeal samples at day 6 or 7. 7, 18 RT-PCR tests using upper and lower respiratory specimens (including nasopharyngeal and oropharyngeal swabs) are recommended for diagnosis of COVID-19; 19, 21 however, dynamics of SARS-Cov-2 in infected patients (untreated or treated) and presence

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of the virus at various body sites over the course of infection have not been fully determined. 22, 23

**Hydroxychloroquine with azithromycin randomized, double-blind, placebo-controlled trial sponsored by NIAID (A5395; NCT04358068):** Symptomatic adults with COVID-19 not currently requiring hospitalization will be randomized to receive hydroxychloroquine (400 mg twice daily on day 1, then 200 mg twice daily for 6 days) and azithromycin (500 mg on day 1, then 250 mg once daily for 4 days) or placebo and followed for 23 weeks to determine whether the combined regimen will prevent hospitalization and death. 10, 48

Multiple clinical trials to evaluate hydroxychloroquine for treatment of COVID-19 are registered at clinicaltrials.gov (some listed below): 10

- NCT04329923
- NCT04332991
- NCT04334967
- NCT04335552
- NCT04341727
- NCT04345692
- NCT04350450
- NCT04351620
- NCT04353037
- NCT04362332

Multiple clinical trials to evaluate hydroxychloroquine for prevention of COVID-19 in the healthcare setting or in household contacts of pts with the disease are registered at clinicaltrials.gov (some listed below): 10

- NCT04318015
- NCT04318444
- NCT04328961
- NCT04331834
- NCT04333225
- NCT04341441
- NCT04363450
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<td>Neuraminidase inhibitors (e.g., oseltamivir)</td>
<td>8:18.28</td>
<td>Antivirals active against influenza viruses</td>
<td>In a retrospective case series of 99 patients with COVID-19 at single center in Wuhan from 1/1/20 to 1/20/20, 76% of patients received antiviral treatment, including oseltamivir (75 mg orally every 12 hours). At the time of evaluation, 58% of patients remained hospitalized, 31% had been discharged, and 11% had died. (^1) While oseltamivir is noted to have been widely used for confirmed or suspected COVID-19 cases in hospitals in China, there has been no exact evidence to date that oseltamivir is effective in the treatment of COVID-19. (^2) Neither oseltamivir nor zanamivir has demonstrated inhibition of cytopathic effect against SARS-CoV in in vitro cell culture. (^4) Clinicaltrials.gov trials for COVID-19 that include oseltamivir(^2): NCT04303299 NCT04261270 NCT04255017 NCT0438698</td>
<td>Dosage of oseltamivir in the case series of 99 patients was 75 mg orally every 12 hours. (^1) Dosages of oseltamivir from registered trials (either recruiting, or not yet recruiting) vary, but include 300 mg orally daily, 75 mg orally once or twice daily, and 4–6 mg/kg orally (frequency not specified). (^7)</td>
<td>No data to date support use in the treatment of COVID-19</td>
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| Remdesivir | 8:18.32 | Antiviral | Various clinical trials initiated in US, China, and other countries | Optimal dosage and duration of treatment not known \(^5\), \(^6\) Phase 3 trial protocol (severe COVID-19): 200 mg IV on day 1, then 100 mg IV daily on days 2-5 (arm 1) or 200 mg IV on day 1, then 100 mg IV daily on days 2-10 (arm 2); \(^10\) 200 mg IV on day 1, then 100 mg IV daily on days 2-10 (extension arms that include pts who are or are not receiving mechanical ventilation) \(^15\) Phase 3 trial protocol (moderate COVID-19): 200 mg IV on day 1, then 100 mg IV on days 2-5 (arm 1) or 200 mg IV on day 1, then 100 mg IV daily on days 2-10 (arm 2) \(^11\) NIAID adaptive study protocol: 200 mg IV on day 1, then 100 mg IV for duration of hospitalization up to 10 days total \(^13\) | Not commercially available; most promising direct-acting antiviral (DAA) currently being investigated for COVID-19 Efficacy and safety of remdesivir for treatment of COVID-19 not established NIH COVID-19 Treatment Guidelines Panel recommends use of remdesivir for the treatment of COVID-19 in hospitalized patients with severe disease; the NIH panel does not recommend remdesivir for the treatment of mild or moderate COVID-19 outside of clinical trials. \(^20\) Emergency use authorization (EUA) for remdesivir: FDA issued an EUA on May 1, 2020 that permits use of the drug for the treatment of COVID-19 only in hospitalized adults and children with suspected or laboratory-confirmed COVID-19 who have severe disease (defined as

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### Drug(s) | AHFS Class | Rationale | Trials or Clinical Experience | Dosage | Comments
--- | --- | --- | --- | --- | ---
Remdesivir | - | - | In vitro activity against SARS-CoV and MERS-CoV; active in animal models of SARS and MERS; prevented MERS in Rhesus macaques when given before infection and provided benefits when given after animal already infected. Pharmacokinetic data available from evaluations for Ebola | (14 vs 13%). When remdesivir was initiated within 10 days of symptom onset, median time to clinical improvement was numerically shorter (but not statistically significant) compared with placebo group (18 vs 23 days). Duration of invasive mechanical ventilation was numerically shorter (but not statistically significant) in remdesivir group; only a small percentage of pts (0.4%) were on invasive mechanical ventilation at time of enrollment. Remdesivir did not result in significant reduction in SARS-CoV-2 viral load in nasopharyngeal, oropharyngeal, and sputum samples. Remdesivir was discontinued in 18 pts (12%) because of adverse effects. Note: Enrollment was terminated before the pre-specified number of pts was attained (lack of available pts); trial was insufficiently powered to detect assumed differences in clinical outcome. | Compassionate use access protocol: 200 mg IV on day 1, then 100 mg IV on days 2-10. Emergency use authorization (EUA) dosage recommended for adults and children weighing 40 kg or more: Loading dose of 200 mg by IV infusion on day 1, followed by 100 mg by IV infusion once daily on days 2-10 (for pts requiring invasive mechanical ventilation and/or ECMO) or followed by 100 mg by IV infusion once daily on days 2-5 with option to extend treatment up to day 10 if needed (for pts not requiring mechanical ventilation and/or ECMO). Emergency use authorization (EUA) dosage recommended for children weighing 3.5 to less than 40 kg: 5 mg/kg by IV infusion on day 1, followed by 2.5 mg/kg by IV infusion once daily on days 2-10 (for pts requiring invasive mechanical ventilation and/or ECMO) or followed by 2.5 mg/kg by IV infusion once daily on days 2-5 with option to extend treatment up to day 10 if needed (for pts not requiring mechanical ventilation and/or ECMO). | -

**Pharmaceutical company announced** that data available for the initial 397 pts not requiring mechanical ventilation at study entry (200 received a 5-day regimen and 197 received a 10-day regimen) indicate similar clinical improvement with both treatment durations. Time to clinical improvement for 50% of pts was 10 days in the 5-day treatment group vs 11 days in the 10-day treatment group. At day 14, 129/200 pts (64.5%) in the 5-day group and 106/197 pts (53.8%) in the 10-day group achieved clinical recovery. Pts who received remdesivir within 10 days of symptom onset had improved outcomes.**

The manufacturer (Gilead) donated remdesivir for use under the EUA; distribution to hospitals and other healthcare facilities is being directed by the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) in collaboration with state health departments. To request remdesivir for use under the EUA, healthcare providers should contact their state health departments. The EUA requires that healthcare facilities and healthcare providers administering remdesivir comply with certain mandatory record keeping and reporting requirements (including adverse event reporting to FDA MedWatch). Consult the EUA, EUA fact sheet for healthcare providers, and EUA fact sheet for patients and parent/caregivers for additional information.

### Notes

- **Rationale:**
  - In vitro activity against SARS-CoV and MERS-CoV; active in animal models of SARS and MERS; prevented MERS in Rhesus macaques when given before infection and provided benefits when given after animal already infected. Pharmacokinetic data available from evaluations for Ebola.

- **Trials or Clinical Experience:**
  - Phase 3 randomized, open-label trial in hospitalized adults with severe COVID-19 (NCT04292899) sponsored by the manufacturer (Gilead): Initial study protocol designed to evaluate safety and antiviral activity of 5- and 10-day regimens of remdesivir (200 mg IV on day 1, followed by 100 mg once daily for 5 or 10 days) in conjunction with standard of care in pts not receiving mechanical ventilation; protocol subsequently modified to add extension arms to evaluate safety and efficacy of 10-day regimen of remdesivir in conjunction with standard of care in pts who are or are not receiving mechanical ventilation. Manufacturer announced that data available for the initial 397 pts not requiring mechanical ventilation at study entry (200 received a 5-day regimen and 197 received a 10-day regimen) indicate similar clinical improvement with both treatment durations. Time to clinical improvement for 50% of pts was 10 days in the 5-day treatment group vs 11 days in the 10-day treatment group. At day 14, 129/200 pts (64.5%) in the 5-day group and 106/197 pts (53.8%) in the 10-day group achieved clinical recovery. Pts who received remdesivir within 10 days of symptom onset had improved outcomes.

- **Dosage:**
  - **Compassionate use access protocol:** 200 mg IV on day 1, then 100 mg IV on days 2-10.
  - **Emergency use authorization (EUA) dosage recommended for adults and children weighing 40 kg or more:** Loading dose of 200 mg by IV infusion on day 1, followed by 100 mg by IV infusion once daily on days 2-10 (for pts requiring invasive mechanical ventilation and/or ECMO) or followed by 100 mg by IV infusion once daily on days 2-5 with option to extend treatment up to day 10 if needed (for pts not requiring mechanical ventilation and/or ECMO).
  - **Emergency use authorization (EUA) dosage recommended for children weighing 3.5 to less than 40 kg:** 5 mg/kg by IV infusion on day 1, followed by 2.5 mg/kg by IV infusion once daily on days 2-10 (for pts requiring invasive mechanical ventilation and/or ECMO) or followed by 2.5 mg/kg by IV infusion once daily on days 2-5 with option to extend treatment up to day 10 if needed (for pts not requiring mechanical ventilation and/or ECMO).

- **Comments:**
  - The manufacturer (Gilead) donated remdesivir for use under the EUA; distribution to hospitals and other healthcare facilities is being directed by the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) in collaboration with state health departments. To request remdesivir for use under the EUA, healthcare providers should contact their state health departments. The EUA requires that healthcare facilities and healthcare providers administering remdesivir comply with certain mandatory record keeping and reporting requirements (including adverse event reporting to FDA MedWatch). Consult the EUA, EUA fact sheet for healthcare providers, and EUA fact sheet for patients and parent/caregivers for additional information.

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compared with those treated after more than 10 days of symptoms.  

**Note:** Data regarding this initial pt population (e.g., disease severity and comorbidities at study enrollment, additional supportive treatment received) not provided to date.

**Phase 3 randomized, open-label trial in pts with moderate COVID-19 (NCT04292730)**

sponsored by the manufacturer (Gilead) is evaluating safety and antiviral activity of 5- and 10-day regimens of remdesivir in conjunction with standard of care compared with standard of care alone.

**Phase 3 adaptive, randomized, double-blind, placebo-controlled trial (NIAID Adaptive COVID-19 Treatment Trial 1 [ACTT-1]; NCT04280705) in hospitalized adults with COVID-19:** 1063 pts were randomized 1:1 to receive remdesivir (200 mg IV on day 1, then 100 mg once daily on days 2-10 or until hospital discharge or death) or placebo.  

All pts received supportive care according to the standard of care for the trial site hospital. Baseline demographics and clinical characteristics (e.g., age, disease severity, comorbidities at study enrollment, time to initiation of treatment after symptom onset) were similar in both groups. Overall, 88.7% of pts had severe disease at study enrollment and the median time from symptom onset to randomization was 9 days (range: 6-13 days). Preliminary data analysis that included 1059 pts (538 received remdesivir and 521 received placebo) indicated shorter median time to recovery in the remdesivir group (11 days) vs the placebo group (15 days) and suggested that remdesivir treatment may have provided a survival benefit (Kaplan-Meier estimates of mortality by day 14 were 7.1% in the remdesivir group vs 11.9% in the placebo group).

**Expanded access IND protocol (NCT04323761):**

The manufacturer (Gilead) established a protocol for emergency access to remdesivir for the treatment of severe acute COVID-19 in hospitalized adults and children 12 years of age or older.
Compassionate use access: The manufacturer (Gilead) has transitioned from individual compassionate use requests to expanded access programs for emergency access to the drug for the treatment of severe COVID-19. The only individual compassionate use requests for the drug still being reviewed by the manufacturer are those for pregnant women and children <18 years of age with confirmed COVID-19 and severe manifestations of the disease.  
https://rdvcu.gilead.com/

Compassionate use access (NCT04302766): May be available for DoD personnel through treatment IND protocol sponsored by US Army Medical Research and Development Command

Data from the manufacturer’s compassionate use program: Preliminary data are available for a cohort of 53 adults from multiple sites in the US, Italy, Japan, and other countries who were hospitalized with severe COVID-19 and received treatment with remdesivir; 40 pts received the full 10-day regimen (200 mg IV on day 1, then 100 mg IV on days 2-10), 10 pts received 5-9 days and 3 pts received less than 5 days of treatment with the drug. At baseline, 30 pts (57%) were receiving mechanical ventilation and 4 (18%) were receiving extracorporeal membrane oxygenation (ECMO). Over a median follow-up of 18 days after first dose, 36 pts (68%) showed clinical improvement based on oxygen-support status and 8 pts (15%) worsened. There were 7 deaths (13%), including 6 pts receiving invasive ventilation. Adverse effects (e.g., increased hepatic enzymes, diarrhea, rash, renal impairment, hypotension) were reported in 32 pts (60%); 12 pts (23%) had serious adverse effects (e.g., multiple organ dysfunction syndrome, septic shock, acute kidney injury, hypotension); 4 pts (8%) discontinued the drug because of adverse effects. Note: Data presented for this small cohort of pts offers only limited information regarding efficacy and safety of remdesivir for treatment of COVID-19. There was no control group and, although supportive therapy could be provided at

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*Note: Data presented for this small cohort of pts offers only limited information regarding efficacy and safety of remdesivir for treatment of COVID-19. There was no control group and, although supportive therapy could be provided at
Updated 5/8/20. The current version of this document can be found on the ASHP COVID-19 Resource Center.

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<tr>
<td>Umifenovir (Arbidol®)</td>
<td>8:18.92</td>
<td>Antiviral</td>
<td>Broad-spectrum antiviral with in vitro activity against various viruses, including coronaviruses 4, 5 Although data limited, in vitro activity against SARS-CoV-1 4 and SARS-CoV-2 5 reported Licensed in China, Russia, Ukraine, and possibly other countries for prophylaxis and treatment of influenza 4</td>
<td><a href="#">Retrospective cohort study</a> in 50 adults with COVID-19 in China suggests better viral suppression with umifenovir vs LPV/RTV. All pts received conventional therapy, including interferon α-2b. At 7 days after hospital admission, SARS-CoV-2 was undetectable in 50% of pts treated with umifenovir vs 23.5% treated with LPV/RTV; at 14 days, viral load undetectable in all pts treated with umifenovir vs 44.1% treated with LPV/RTV. Duration of positive SARS-CoV-2 RNA positive test was shorter with umifenovir vs LPV/RTV 8</td>
<td>Dosage recommended for treatment of COVID-19 in China: Adults, 200 mg orally 3 times daily for no more than 10 days 5, 7 Dosage used or being investigated in COVID-19 clinical trials: 200 mg orally 3 times daily for duration of 7-10 days or longer 2, 3, 6, 8</td>
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<td>Drug(s)</td>
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<td>undetectable in 15/16 pts (94%) treated with both drugs vs 9/17 pts (53%) treated with LPV/RTV alone. At 7 days, chest CT scans were improving in 11/16 pts (69%) treated with both drugs vs 5/17 pts (29%) treated with LPV/RTV alone&lt;sup&gt;1&lt;/sup&gt;</td>
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<td><strong>Retrospective cohort study</strong> in 81 hospitalized, non-ICU adults with COVID-19 in China found no difference in clearance of SARS-CoV-2 virus between pts receiving umifenovir vs those who did not. At 7 days, SARS-CoV-2 undetectable in pharyngeal specimens in 33/45 pts (73.3%) treated with umifenovir vs 28/36 pts (77.8%) who did not receive umifenovir. No difference in median time from onset of symptoms to negative SARS-CoV-2 test (18 vs 16 days)&lt;sup&gt;9&lt;/sup&gt;</td>
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<td><strong>Open-label, prospective, randomized, multicenter study</strong> in 236 adults with COVID-19 in China (ChiCTR200030254): When favipiravir was compared with umifenovir, clinical recovery rate was greater in those treated with favipiravir than in those treated with umifenovir.&lt;sup&gt;6&lt;/sup&gt; (See Favipiravir in this Evidence Table.)</td>
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<td><strong>Randomized, single-center, partially blind trial in China</strong> (NCT0425885) evaluated efficacy of umifenovir in conjunction with standard care vs LPV/RTV in conjunction with standard care vs standard care without an antiviral in hospitalized adults with mild/moderate COVID-19&lt;sup&gt;2-10&lt;/sup&gt;. Data for the 86 enrolled pts suggest no difference in mean time for positive-to-negative conversion of SARS-CoV-2 nucleic acid in respiratory specimens and no difference in clinical outcomes between pts treated with umifenovir or LPV/RTV compared with no antiviral therapy&lt;sup&gt;10&lt;/sup&gt;.</td>
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<td><strong>NCT04260594 (not yet recruiting):</strong> Randomized, open-label trial evaluating efficacy and safety of umifenovir in conjunction with standard of care in adults with COVID-19&lt;sup&gt;3&lt;/sup&gt;</td>
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## SUPPORTING AGENTS

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<tr>
<td><strong>Anakinra</strong>&lt;br&gt;Updated 5/28/20</td>
<td>92:36 Disease-modifying Anti-rheumatic Drug</td>
<td>Recombinant human interleukin-1 (IL-1) receptor antagonist 1&lt;br&gt;&lt;br&gt;IL-1 levels are elevated in patients with COVID-19; anakinra may potentially combat cytokine release syndrome (CRS) symptoms in severely ill COVID-19 patients 2,3,4,7</td>
<td>Currently no known published controlled clinical trial evidence supporting efficacy or safety of anakinra in treating COVID-19 7&lt;br&gt;&lt;br&gt;Encouraging preliminary results reported in China with another disease-modifying anti-rheumatic drug, tocilizumab 5,6&lt;br&gt;&lt;br<strong>France</strong>: A small case series (9 patients) of open-label anakinra treatment in hospitalized (non-ICU) adults with moderate to severe COVID-19 pneumonia has been published with encouraging results 8&lt;br&gt;&lt;br<strong>Italy</strong>: Phase 3 randomized, open-label, multicenter trial (NCT04324021) initiated by the manufacturer (Swedish Orphan Bioproducts) to evaluate efficacy and safety of anakinra or emapalumab with standard of care in reducing hyperinflammation and respiratory distress in patients with COVID-19 is recruiting 3&lt;br&gt;&lt;br&gt;Other noncomparative, open-label trials are recruiting in Greece (NCT04356366, NCT04397121) and Belgium (NCT04330638) 1</td>
<td>Various dosage regimens are being studied 1,8&lt;br&gt;&lt;br&gt;Trial protocol in Italy (COVID-19 with hyperinflammation and respiratory distress): 100 mg by IV infusion every 6 hours (total of 400 mg daily) for 15 days 5&lt;br&gt;&lt;br&gt;Some studies under way in Greece and Belgium are evaluating 100 mg given subcutaneously once daily for 10 or 28 days, respectively, or until hospital discharge 3&lt;br&gt;&lt;br&gt;In a French case series, anakinra was given subcutaneously in a dosage of 100 mg every 12 hours on days 1-3, then 100 mg once daily from day 4-10 8&lt;br&gt;&lt;br&gt;(Note: Anakinra is approved only for subcutaneous administration in the U.S.) 1,7</td>
<td>Insufficient clinical data to recommend either for or against use in the treatment of COVID-19 7&lt;br&gt;&lt;br<strong>Safety profile</strong>: Well established in adults with sepsis and has been studied extensively in severely ill pediatric patients with complications of rheumatologic conditions; pediatric data on use in acute respiratory distress syndrome/sepsis are limited 7&lt;br&gt;&lt;br<strong>Pregnancy</strong>: Limited evidence to date: unintentional first trimester exposure considered unlikely to be harmful 7</td>
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<td><strong>Ascorbic acid</strong>&lt;br&gt;Updated 5/6/20</td>
<td>88:12 Vitamin C</td>
<td>Antioxidant and cofactor for numerous physiologic reactions; may support host defenses against infection and protect host cells against infection-induced oxidative stress 3-5,7&lt;br&gt;&lt;br&gt;Presence of infection may decrease vitamin C concentrations 2,5</td>
<td><strong>IV ascorbic acid</strong>: Phase 3 randomized, blinded, placebo-controlled trial (NCT03680274; LOVIT) evaluating effect of high-dose IV ascorbic acid on mortality and persistent organ dysfunction in septic ICU patients (including COVID-19 patients); other clinical trials of high-dose IV ascorbic acid for treatment of COVID-19 also registered: 1&lt;br&gt;&lt;br&gt;NCT04264533&lt;br&gt;&lt;br&gt;NCT04323514&lt;br&gt;&lt;br&gt;NCT04363216&lt;br&gt;&lt;br&gt;NCT04357782&lt;br&gt;&lt;br&gt;NCT04344184&lt;br&gt;&lt;br&gt;<strong>Oral ascorbic acid</strong>: Randomized, open-label study (NCT04342728; COVIDAToZ) initiated to evaluate oral ascorbic acid (8 g daily), zinc, or both in combination in symptomatic outpatients receiving a positive COVID-19 test result 5</td>
<td>Various dosages of IV ascorbic acid used in COVID-19 studies; 50 mg/kg IV every 6 hours for 4 days used in NCT03680274 1&lt;br&gt;&lt;br&gt;Various dosages of IV ascorbic acid used in sepsis studies; 50 mg/kg every 6 hours for 4 days used in CITRIS-ALI study; 1.5 g every 6 hours until shock resolution or for up to 10 days used in VITAMIN study 1,6-10&lt;br&gt;&lt;br&gt;NCT04342728: Oral ascorbic acid dosage of 8 g daily, given in 2 or 3 divided doses 1&lt;br&gt;&lt;br&gt;Note: May interfere with laboratory tests based on oxidation-reduction reactions (e.g., blood and urine glucose testing, nitrite and bilirubin concentrations, leukocyte counts).</td>
<td>Current data not specific to COVID-19; additional study needed 6</td>
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Azithromycin  
*Updated 5/28/20*

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| Azithromycin | 8:12.12 Macrolides | Antibacterial with some in vitro activity against some viruses (e.g., influenza A H1N1, Zika) 1, 3-5 | Included at lower dosages as an active or placebo-equivalent comparator (control) in other COVID-19 prevention or treatment studies 1  
Included as a component of some hydroxychloroquine-based combination regimens being studied for prevention or treatment of COVID-19 7 | Manufacturer states to delay oxidation-reduction reaction-based tests until 24 hours after infusion, if possible 11 | |
| Azithromycin* |  | Adjunctive therapy in certain respiratory viral infections: Although contradictory results reported, some evidence of beneficial immunomodulatory or anti-inflammatory effects when used in pts with some viral infections (e.g., influenza). 10, 12, 13  
However, in a retrospective cohort study in critically ill pts with laboratory-confirmed MERS, there was no statistically significant difference in 90-day mortality rates or clearance of MERS-CoV RNA between those who received macrolide therapy and those who did not. 12 | | Adjunctive treatment in certain viral infections: 500 mg once daily has been used 13  
COVID-19: 500 mg on day 1, then 250 mg once daily on days 2-5 in conjunction with a 5-, 7-, or 10-day regimen of hydroxychloroquine has been used or is being investigated 7, 18, 19, 23, 24, 28 | Current data insufficient to establish pros and cons of adjunctive use of azithromycin in management of COVID-19  
Additional data needed from randomized, controlled clinical trials before any conclusions can be made regarding possible benefits of using a combined regimen of hydroxychloroquine and azithromycin in pts with COVID-19  
NIH COVID-19 Treatment Guidelines Panel recommends against the use of a combined regimen of hydroxychloroquine and azithromycin for the treatment of COVID-19, except in the context of a clinical trial. 21 (See Hydroxychloroquine in this Evidence Table.)  
IDSA recommends that a combined regimen of hydroxychloroquine |
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<td>Azithromycin</td>
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<td>Reported in those who received adjunctive azithromycin. 8</td>
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<td>Clinical experience in pts with COVID-19:</td>
<td>Has been used for antibacterial coverage in hospitalized pts with COVID-19 15</td>
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<td>Use in conjunction with hydroxychloroquine in pts with COVID-19:</td>
<td>Azithromycin (500 mg on day 1, then 250 mg daily on days 2-5) has been used in addition to a 10-day regimen of hydroxychloroquine (600 mg daily) in an open-label nonrandomized study in France (6 pts), 7 open-label uncontrolled study in France (11 pts), 18 uncontrolled observational study in France (80 pts), 19 and larger uncontrolled observational study in France (1061 pts). 23 Data presented to date are insufficient to evaluate possible clinical benefits of azithromycin in pts with COVID-19. (See Hydroxychloroquine in this Evidence Table.)</td>
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<td>Use in conjunction with chloroquine or hydroxychloroquine in hospitalized pts with COVID-19:</td>
<td>Data from 2 retrospective studies that analyzed outcome data for hospitalized pts in New York treated with hydroxychloroquine with or without azithromycin 30,31 and data from a large, multinational, retrospective study that analyzed outcome data for hospitalized pts treated with chloroquine or hydroxychloroquine with or without a macrolide (azithromycin or clarithromycin) 32 indicate that use of these 4-aminoquinoline antimalarials with or without a macrolide is not associated with decreased in-hospital mortality. 30-32 In addition, there was evidence from the large, multinational study that the risk of de-novo ventricular arrhythmia is increased when chloroquine or hydroxychloroquine is used with a macrolide. 32 (See Hydroxychloroquine in this Evidence Table.)</td>
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<td>Randomized, double-blind, placebo-controlled trial sponsored by NIAID initiated to evaluate efficacy of hydroxychloroquine with azithromycin for prevention of</td>
<td>(or chloroquine) and azithromycin be used for the treatment of COVID-19 only in the context of a clinical trial. 22</td>
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<td>Baricitinib</td>
<td>92:36 Disease-modifying Anti-rheumatic Drug</td>
<td>Janus kinase (JAK) 1 and 2 inhibitor; disrupts regulators of endocytosis (AP2-associated protein kinase 1 [AAK1] and cyclin G-associated kinase [GAK]), which may help reduce viral entry and inflammation; also may interfere with intracellular virus particle assembly. Inhibits JAK1 and JAK2-mediated cytokine release; may combat cytokine release syndrome (CRS) in severely ill patients. Ability to inhibit a variety of proinflammatory cytokines, including interferon, has been raised as a possible concern with the use of JAK inhibitors in the management of hyperinflammation resulting from viral infections such as COVID-19.</td>
<td>Currently no known published controlled clinical trial evidence supporting efficacy or safety in patients with COVID-19. In a small (12 patients) open-label study in Italy (NCT04358614), use of baricitinib (4 mg orally once daily for 2 weeks) in combination with lopinavir/ritonavir was evaluated in patients with moderate COVID-19 pneumonia. Baricitinib was well tolerated with no serious adverse events reported. At week 1 and week 2, patients who received baricitinib had significant improvement in respiratory function parameters and none of the patients required ICU support. Baricitinib is included in the next iteration of NIAID’s Adaptive COVID-19 Treatment Trial (ACTT 2). Inclusion criteria: Laboratory-confirmed COVID-19 infection and evidence of lung involvement, including need for supplemental oxygen, abnormal chest X-ray, or need for mechanical ventilation. Patients randomized to receive treatment with remdesivir with or without baricitinib. Remdesivir to be administered as one 200-mg IV dose on day 1 followed by 100 mg IV daily for the duration of hospitalization (up to 10-day treatment course). Baricitinib to be administered as a 4-mg oral dose administered once daily for the duration of hospitalization (up to 14-day treatment course).</td>
<td>Therapeutic dosages of baricitinib (2 or 4 mg orally once daily) are sufficient to inhibit AAK1. Dosage information not yet available (see Trials or Clinical Experience)</td>
<td>Minimal interaction with CYP enzymes and drug transporters and low protein binding of baricitinib allow for combined use with antiviral agents and other drugs. NIH COVID-19 Treatment Guidelines Panel recommends against use of JAK inhibitors for the treatment of COVID-19 except in the context of a clinical trial; the panel states that at present the broad immunosuppressive effect of JAK inhibitors outweighs the potential for benefit.</td>
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<td>Colchicine</td>
<td>92:16 Anti-</td>
<td>Exerts broad anti-inflammatory and immunomodulatory effects through multiple mechanisms, including inhibition of NOD-like receptor protein 3 (NLRP3) inflammasome assembly and disruption of cytoskeletal functions through inhibition of microtubule polymerization. May combat the hyper-inflammatory state of COVID-19 (e.g., cytokine storm) by suppressing proinflammatory cytokines and chemokines. NLRP3 inflammasome activation results in release of interleukins, including IL-1β. In experimental models of acute respiratory distress syndrome/acute lung injury (ARDS/ALI), the NLRP3 inflammasome had a major role in the development of lung injury. Potential to limit COVID-19-related myocardial damage also has been hypothesized based on the drug’s mechanisms of action and promising results of ongoing research on</td>
<td>Adaptive phase 2/3 clinical trial: Open-label study planned to evaluate safety and efficacy of baricitinib in hospitalized patients with COVID-19 (NCT04340232). Other planned clinical trials will evaluate baricitinib in combination with or without an antiviral agent for the treatment of COVID-19 (NCT04346147, NCT04320277, NCT04345289, NCT04321993).</td>
<td>Minimal anecdotal experience and no clinical trial data reported to date in COVID-19.</td>
<td>0.5 mg orally twice daily for 3 days, then 0.5 mg once daily for 27 days. Consider possible need for colchicine dosage adjustment; manufacturer-recommended dosages for labeled indications depend on patient’s age, renal and hepatic function, and concomitant use of interacting drugs, including protease inhibitors (e.g., lopinavir/ritonavir), other moderate or potent CYP3A4 inhibitors, and P-glycoprotein (P-gp) inhibitors. Use of colchicine in patients with renal or hepatic impairment receiving P-gp inhibitors or potent CYP3A4 inhibitors is contraindicated.</td>
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<p>| Added 4/24/20 | * | | | | | |</p>
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<tr>
<th>Drug(s)</th>
<th>AHFS Class</th>
<th>Rationale</th>
<th>Trials or Clinical Experience</th>
<th>Dosage*</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Corticosteroids (general)</td>
<td>68:04 Adrenals</td>
<td>Potent anti-inflammatory and antifibrotic properties; use of corticosteroids may prevent an extended cytokine response and may accelerate resolution of pulmonary and systemic inflammation in pneumonia. Evidence suggests that cytokine storm, a hyperinflammatory state resembling secondary hemophagocytic lymphohistiocytosis (HLH), is a contributing factor in COVID-19-associated mortality. Uncontrolled observational data from the recent COVID-19 outbreak in China suggest a possible treatment benefit of methylprednisolone in COVID-19 patients with acute respiratory distress syndrome (ARDS). (See Methylprednisolone in this Evidence Table.) Pending results of randomized controlled clinical studies specifically evaluating corticosteroids for COVID-19, indirect evidence from studies in patients with community-acquired pneumonia, ARDS, and other viral infections has been used to inform treatment decisions for COVID-19 patients. Systemic corticosteroid therapy has been studied in several randomized controlled studies for the treatment of ARDS; overall evidence is low to moderate in quality and most studies were performed prior to the prelung protection strategy era. In a recent multicenter, unblinded, randomized controlled study (DEXA-ARDS trial), the effects of dexamethasone in conjunction with conventional care were evaluated in hospitalized patients with moderate-to-severe ARDS receiving lung-protective mechanical ventilation. Treatment with IV dexamethasone at a dosage</td>
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<td><strong>Observational studies:</strong> Evidence suggests that corticosteroid use in patients with SARS, MERS, and influenza was associated with no survival benefit and possible harm (e.g., delayed viral clearance, avascular necrosis, psychosis, diabetes). Uncontrolled observational data from the recent COVID-19 outbreak in China suggest a possible treatment benefit of methylprednisolone in COVID-19 patients with acute respiratory distress syndrome (ARDS). (See Methylprednisolone in this Evidence Table.) Pending results of randomized controlled clinical studies specifically evaluating corticosteroids for COVID-19, indirect evidence from studies in patients with community-acquired pneumonia, ARDS, and other viral infections has been used to inform treatment decisions for COVID-19 patients. Systemic corticosteroid therapy has been studied in several randomized controlled studies for the treatment of ARDS; overall evidence is low to moderate in quality and most studies were performed prior to the prelung protection strategy era. In a recent multicenter, unblinded, randomized controlled study (DEXA-ARDS trial), the effects of dexamethasone in conjunction with conventional care were evaluated in hospitalized patients with moderate-to-severe ARDS receiving lung-protective mechanical ventilation. Treatment with IV dexamethasone at a dosage</td>
<td>In general, low to moderate dosages of corticosteroids are recommended in intubated patients with ARDS. Regimens used in China were typically methylprednisolone 40-80 mg IV daily for a course of 3-6 days. Some experts suggest that equivalent dosages of dexamethasone (i.e., 7-15 mg daily, typically 10 mg daily) may have an advantage of producing less fluid retention, since dexamethasone has less mineralocorticoid activity. This dosage of dexamethasone is consistent with those used in the DEXA-ARDS trial. Higher dosages have been suggested for cytokine storm. (See Comments column.)</td>
<td>Data on the use of corticosteroids in COVID-19 are limited. NIH, CDC, WHO, IDSA, and other experts have issued guidelines for the use of corticosteroids in patients with COVID-19 based on the currently available information. Recommendations are made according to the severity of illness, indications, and underlying medical conditions and should be considered on a case-by-case basis. General recommendations: WHO, CDC, NIH, and IDSA generally recommend against the routine use of corticosteroids for the treatment of COVID-19 unless indicated for another reason (e.g., asthma or COPD exacerbation, refractory septic shock). Non-critical patients: Corticosteroids generally should not be used in the treatment of early or mild disease since the drugs can inhibit immune response, reduce pathogen clearance, and increase viral shedding. NIH recommends against the routine use of systemic corticosteroids for the treatment of COVID-19 in hospitalized patients unless they are in the intensive care unit.</td>
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<td>Trials or Clinical Experience</td>
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<td>of 20 mg once daily on days 1-5, followed by 10 mg once daily on days 6-10 resulted in reduced duration of mechanical ventilation and reduced overall mortality (i.e., 15% increase in 60-day survival) compared with conventional treatment alone. Based on results of this study, a clinical trial (NCT04325061) has been initiated to specifically evaluate the use of dexamethasone in patients with ARDS due to COVID-19. Other clinical trials have been initiated in various countries to evaluate use of IV corticosteroids (e.g., dexamethasone, hydrocortisone), oral corticosteroids (e.g., prednisone), or inhaled corticosteroids (e.g., budesonide, ciclesonide) for treatment of COVID-19 pneumonia or ARDS, including the following trials registered at clinicaltrials.gov: NCT04327401 NCT04344288 NCT04344730 NCT04348305 NCT04355637 NCT04359511 NCT04360876 NCT04381364 (For registered clinical trials evaluating use of methylprednisolone, see Methylprednisolone in this Evidence Table.) Randomized controlled studies evaluating use of corticosteroids (e.g., hydrocortisone, dexamethasone, methylprednisolone, prednisolone) in septic shock suggest a small, but uncertain mortality reduction.</td>
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<td><strong>Septic shock</strong>: The effect of corticosteroids in COVID-19 patients with sepsis or septic shock may be different than the effects seen in those with ARDS. The Surviving Sepsis Campaign and NIH suggest the use of low-dose corticosteroid therapy (e.g., hydrocortisone 200 mg daily as an IV infusion or intermittent doses) over no corticosteroid therapy in adults with COVID-19 and refractory shock. Clinicians considering corticosteroids for such patients with COVID-19 should balance the potential small reduction in mortality with potential effects of prolonged coronavirus shedding. If corticosteroids are prescribed, monitor and treat adverse effects including hyperglycemia, hypernatremia, and hypokalemia. Patients receiving corticosteroid therapy for chronic conditions: NIH states that oral corticosteroids used for the treatment of an underlying condition prior to COVID-19 infection (e.g., primary or secondary adrenal insufficiency, rheumatologic diseases) should not be discontinued. Supplemental or stress dosages of corticosteroids may be indicated on an individual basis in patients with such conditions. The guidelines also recommend that inhaled corticosteroids used daily for the management of asthma and COPD to control airway inflammation should not be discontinued in patients with COVID-19. Rheumatology experts, including members of the American College of Rheumatology COVID-19 Clinical Guidance Task Force, state that abrupt discontinuance of corticosteroid therapy in patients with rheumatologic diseases should be avoided regardless of COVID-19 exposure or infection status. These experts also state that if indicated, corticosteroids should be used at the lowest effective dosage to control manifestations, but also acknowledge that higher dosages may be necessary in the context</td>
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of severe, vital organ-threatening rheumatologic disease even following COVID-19 exposure. 28-30

Endocrinology experts state that patients with primary or secondary adrenal insufficiency who are receiving prolonged corticosteroid therapy should follow usual steroid “sick day rules” since these individuals may not be able to mount a normal stress response in the event of COVID-19 infection. 19, 26 If such individuals develop symptoms such as fever and a dry continuous cough, they should immediately double their daily oral corticosteroid dosage and continue with this regimen until the fever subsides. 19 These guidelines also apply to patients who are receiving prolonged therapy (> 3 months) with corticosteroids for underlying inflammatory conditions, including asthma, allergy, and rheumatoid arthritis. 19 In such patients whose condition worsens or in those experiencing vomiting or diarrhea, treatment with parenteral corticosteroids may be necessary. 19, 26 Administration of physiologic stress doses of corticosteroids (e.g., IV hydrocortisone 50-100 mg 3 times daily) and not pharmacologic doses should be considered in all cases to avoid potentially fatal adrenal failure. 19, 20 Additional study is needed to determine the optimum corticosteroid stress dosage regimens in patients with COVID-19. 26, 27 There is some evidence suggesting that continuous IV infusion of hydrocortisone (following an initial IV bolus dose) may provide more stable circulating cortisol concentrations in patients with adrenal insufficiency and reduce the potentially harmful effects of peak and trough concentrations of cortisol on the immune system. 26, 27

**Pregnancy considerations:** For pregnant women with COVID-19, NIH guidelines state that the antenatal use of corticosteroids that cross the placenta (i.e., betamethasone, dexamethasone)
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<th>Drug(s)</th>
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<tbody>
<tr>
<td>Epoprostenol (inhaled)</td>
<td>48:48 Vasodilating Agent</td>
<td>Selective pulmonary vasodilator; may be useful in the adjunctive treatment of acute respiratory distress syndrome (ARDS), a potential complication of COVID-19</td>
<td>No studies evaluating use specifically in COVID-19 patients Experience in patients with ARDS indicates that inhaled epoprostenol can substantially reduce mean pulmonary artery pressure and improve oxygenation in such patients; however, data demonstrating clinical benefit are lacking Various dosages of inhaled epoprostenol have been used in ARDS studies</td>
<td>Dosages up to 50 ng/kg per minute have been used (titrated to response) in patients with ARDS. To provide a clinically important increase in PaO₂ and reduction in pulmonary artery pressure, data from these studies suggest that the most effective and safe dosage appears to be 20-30 ng/kg per minute in adults and 30 ng/kg per minute in pediatric patients</td>
<td>The Surviving Sepsis Campaign states that due to the lack of adequately powered randomized controlled studies, a recommendation cannot be made for or against the use of inhaled prostacyclins in COVID-19 patients with severe ARDS. The NIH COVID-19 Treatment Guidelines Panel and the Surviving Sepsis Campaign state that a trial of inhaled pulmonary vasodilator as rescue therapy may be considered in mechanically ventilated adults with COVID-19, severe ARDS, and hypoxemia despite optimized ventilation and other rescue strategies; if no rapid improvement in oxygenation is observed, the patient should be tapered off treatment.</td>
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<tr>
<td>Interferons</td>
<td>8:18.20 Interferons</td>
<td>Interferons (IFNs) modulate immune responses to some viral infections, in vitro studies indicate only weak induction of IFN following SARS-CoV-2 infection, and a possible role for IFNs in prophylaxis or early treatment of COVID-19 has been suggested to compensate for possibly insufficient endogenous IFN production Only limited clinical trial data available to date specifically evaluating efficacy of IFNs for treatment of COVID-19; for information on additional studies including IFN alfa or IFN beta as a component of combination therapy (e.g., background regimen), see antiviral entries in this Evidence Table Clinical trials are currently evaluating IFN beta-1a or IFN beta-1b, generally added to other antivirals, for treatment of COVID-19, including: NCT04315948 (IFN beta-1a plus lopinavir/ritonavir [LPV/RTV] vs LPV/RTV vs remdesivir vs hydroxychloroquine</td>
<td>IFN beta: Various sub-Q dosages of IFN beta-1a and IFN beta-1b are being evaluated for treatment of COVID-19</td>
<td>Efficacy and safety of IFNs for treatment or prevention of COVID-19 not established Relative effectiveness of different IFNs against SARS-CoV-2 not established</td>
<td>Updated 5/28/20</td>
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<td>Drug(s)</td>
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<td>Trials or Clinical Experience</td>
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<td>Type 1 IFNs (IFN alfa and IFN beta)</td>
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<td>[each regimen given with standard care] vs standard care</td>
<td>Open-label, randomized study in hospitalized adults with COVID-19 (NCT04324463) is evaluating IFN beta-1b 0.25 mg sub-Q on days 1, 3, 5, and 7, either alone or in conjunction with 7-day regimen of hydroxymethylglutaryl-coenzyme A (HMG-CoA) reductase inhibitor (HMG-CoA reductase inhibitor) and 5-day regimen of azithromycin on days 1, 3, and 6 in conjunction with 14-day regimen of LPV/RTV.</td>
<td>Open-label, randomized study in hospitalized adults with COVID-19 (NCT04324463) is evaluating IFN beta-1b 0.25 mg sub-Q on days 1, 3, 5, and 7, either alone or in conjunction with 7-day regimen of hydroxymethylglutaryl-coenzyme A (HMG-CoA) reductase inhibitor (HMG-CoA reductase inhibitor) and 5-day regimen of azithromycin on days 1, 3, and 6 in conjunction with 14-day regimen of LPV/RTV.</td>
<td>results for treatment of COVID-19 are lacking, and toxicity of IFNs outweighs the potential for benefit.</td>
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<td>Peginterferon lambda-1a: For treatment of COVID-19 in adults (NCT04354259, NCT04388709): Peginterferon lambda-1a 180 mcg sub-Q; number of doses (1 dose or 2 doses given 1 week apart) depends on the protocol.</td>
<td>Peginterferon lambda-1a: For treatment of COVID-19 in adults (NCT04354259, NCT04388709): Peginterferon lambda-1a 180 mcg sub-Q; number of doses (1 dose or 2 doses given 1 week apart) depends on the protocol.</td>
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<td>For postexposure prophylaxis of CoV-2 infection in adults (NCT04344600): Two 180-mcg sub-Q doses of peginterferon lambda-1a given 1 week apart.</td>
<td>For postexposure prophylaxis of CoV-2 infection in adults (NCT04344600): Two 180-mcg sub-Q doses of peginterferon lambda-1a given 1 week apart.</td>
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expressed mainly on epithelial (including respiratory epithelial) cells and neutrophils, and is distinct from the ubiquitous type 1 IFN receptor; \(^2, 4, 7, 19\) despite different receptors and expression patterns, type 1 and type 3 IFNs activate similar signaling cascades; \(^2, 4, 7, 19\) unknown whether limited receptor distribution might also affect efficacy

appeared to be shorter in those receiving IFN alfa-2b alone or in combination with umifenovir compared with those receiving umifenovir alone; this exploratory study was small and nonrandomized, and treatment groups were of unequal size and demographically unbalanced in age, comorbidities, and time from symptom onset to treatment. \(^15\)

**Sub-Q peginterferon lambda-1a (not commercially available in U.S.)** is being evaluated for treatment (e.g., NCT04354259, NCT04388709) and postexposure prophylaxis (e.g., NCT04344600) of SARS-CoV-2 infection \(^5\)

Methylprednisolone (DEPO-Medrol®, SOLU-Medrol*)

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<tr>
<th>Drug(s)</th>
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<th>Rationale</th>
<th>Trials or Clinical Experience</th>
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<th>Comments</th>
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<tr>
<td>Methylprednisolone (DEPO-Medrol®, SOLU-Medrol*)</td>
<td>68:04 Adrenal</td>
<td>Potent anti-inflammatory and antifibrotic properties; use of corticosteroids may prevent an extended cytokine response and may accelerate resolution of pulmonary and systemic inflammation in pneumonia (^3, 9) (See Corticosteroids in this Evidence Table.)</td>
<td>Retrospective, observational, single-center study: In 201 patients with confirmed COVID-19 pneumonia who developed ARDS, methylprednisolone appeared to reduce the risk of death. (^6) Among patients with ARDS, of those who received methylprednisolone treatment, 23 of 50 (46%) patients died, while of those who did not receive methylprednisolone, 21 of 34 (61.8%) died. (^2) Retrospective, observational, single-center study: In 46 patients with confirmed severe COVID-19 pneumonia that progressed to acute respiratory failure, use of methylprednisolone was associated with improvement in clinical symptoms (i.e., fever, hypoxia) and a shortened disease course in patients who received the drug compared with those who did not. (^13) Death occurred in 3 patients during hospitalization; 2 of these patients received methylprednisolone. (^13) Open-label, multicenter, randomized controlled study (NCT04244591) was recently completed in China that compared use of methylprednisolone in conjunction with standard care in patients with confirmed COVID-19 infection that progressed to acute respiratory failure; results have not yet been posted. (^23) Multiple clinical trials have been initiated in various countries to evaluate use of</td>
<td>Dosage used in the retrospective study (Wu et al) not provided. (^6) Dosage used in the retrospective study (Wang et al) was 1-2 mg/kg daily IV for 5-7 days. (^13) Dosage used in the randomized, controlled study (NCT04244591) was 40 mg IV every 12 hours for 5 days. (^23) Findings from observational studies suggest that for patients with COVID-19 pneumonia who progress to ARDS, methylprednisolone treatment may be beneficial. However, results should be interpreted with caution because of potential bias (drug used in sickest patients) and small sample size. Confirmation from randomized controlled studies is needed. (^5, 13) (See Corticosteroids in this Evidence Table for general recommendations on corticosteroid use in patients with COVID-19.)</td>
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<td>Drug(s)</td>
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<td>Methylprednisolone</td>
<td>48:48 Vasodilating Agent</td>
<td>Selective pulmonary vasodilator with bronchodilatory and vasodilatory effects in addition to other systemic effects mediated through cGMP-dependent or independent mechanisms; may be useful for supportive treatment of acute respiratory distress syndrome (ARDS), a potential complication of COVID-19. Also has been shown to have antiviral effects.</td>
<td>methylprednisolone for treatment of COVID-19 pneumonia or severe acute respiratory syndrome, including the following trials registered at clinicaltrials.gov: 22 NCT03852537 NCT040463402 NCT04273321 NCT03233592 NCT04296590 NCT04343729 NCT04374071</td>
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<td>Nitric oxide (inhaled)</td>
<td>48:48 Vasodilating Agent</td>
<td>Selective pulmonary vasodilator with bronchodilatory and vasodilatory effects in addition to other systemic effects mediated through cGMP-dependent or independent mechanisms; may be useful for supportive treatment of acute respiratory distress syndrome (ARDS), a potential complication of COVID-19. Also has been shown to have antiviral effects.</td>
<td>A non-randomized pilot study registered at clinicaltrials.gov (NCT04355247) has been initiated to evaluate use of methylprednisolone for the prevention of COVID-19 cytokine storm and progression to respiratory failure. 22</td>
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<td>Nitric oxide (inhaled)</td>
<td>48:48 Vasodilating Agent</td>
<td>Selective pulmonary vasodilator with bronchodilatory and vasodilatory effects in addition to other systemic effects mediated through cGMP-dependent or independent mechanisms; may be useful for supportive treatment of acute respiratory distress syndrome (ARDS), a potential complication of COVID-19. Also has been shown to have antiviral effects.</td>
<td>In the Chen et al. study in severe SARS patients, inhaled nitric oxide therapy was given for 23 days (30 ppm on day 1, followed by 20 and 10 ppm on days 2 and 3, respectively, then weaned on day 4; therapy was resumed at 10 ppm if deteriorating oxygenation occurred)</td>
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<tr>
<td>Nitric oxide (inhaled)</td>
<td>48:48 Vasodilating Agent</td>
<td>Selective pulmonary vasodilator with bronchodilatory and vasodilatory effects in addition to other systemic effects mediated through cGMP-dependent or independent mechanisms; may be useful for supportive treatment of acute respiratory distress syndrome (ARDS), a potential complication of COVID-19. Also has been shown to have antiviral effects.</td>
<td>Various dosing protocols using different methods of delivery are being evaluated in ongoing studies in COVID-19 patients</td>
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<tr>
<td>Nitric oxide (inhaled)</td>
<td>48:48 Vasodilating Agent</td>
<td>Selective pulmonary vasodilator with bronchodilatory and vasodilatory effects in addition to other systemic effects mediated through cGMP-dependent or independent mechanisms; may be useful for supportive treatment of acute respiratory distress syndrome (ARDS), a potential complication of COVID-19. Also has been shown to have antiviral effects.</td>
<td>The NIH COVID-19 Treatment Guidelines Panel and the Surviving Sepsis Campaign recommend against the routine use of inhaled nitric oxide in mechanically ventilated COVID-19 patients with ARDS; however, a trial of inhaled pulmonary vasodilator as rescue therapy may be considered in mechanically ventilated adults with COVID-19, severe ARDS, and hypoxemia despite optimized ventilation and other rescue strategies; if no rapid improvement in oxygenation is observed, the patient should be tapered off treatment</td>
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Updated 5/28/20. The current version of this document can be found on the ASHP COVID-19 Resource Center. This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.
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<th>Drug(s)</th>
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<th>Comments</th>
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<tr>
<td>Ruxolitinib (Jakafi®)</td>
<td>10:00</td>
<td>Antineoplastic Agents</td>
<td>Genetic similarity between SARS-CoV and SARS-CoV-2 suggests potential benefit in patients with COVID-19&lt;sup&gt;1,14&lt;/sup&gt;</td>
<td>Currently no known published clinical trial evidence supporting efficacy or safety in patients with COVID-19</td>
<td>NIH COVID-19 Treatment Guidelines Panel recommends against use of JAK inhibitors for the treatment of COVID-19 except in the context of a clinical trial; the panel states that at present the broad immunosuppressive effect of JAK inhibitors outweighs the potential for benefit&lt;sup&gt;8&lt;/sup&gt;</td>
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**Rationale**: Janus kinase (JAK) 1 and 2 inhibitor; may potentially combat cytokine release syndrome (CRS) in severely ill patients<sup>4,5</sup> Ability to inhibit a variety of proinflammatory cytokines, including interferon, has been raised as a possible concern with the use of JAK inhibitors in the management of hyperinflammation resulting from viral infections such as COVID-19<sup>5,7</sup>

**Trials or Clinical Experience**:
- **Phase 3 randomized, double-blind, placebo-controlled clinical trial** (NCT04362137; RUXCOVID) evaluating ruxolitinib plus standard of care vs standard of care alone is being initiated in patients ≥12 years of age with COVID-19-associated cytokine storm (sponsored by Incyte in U.S. and Novartis outside of U.S.)<sup>1,10</sup>
- **Expanded-access (managed-access, compassionate use) program** (NCT04337359) available for eligible adults and children ≥6 years of age with severe or very severe COVID-19 illness; address inquiries to Incyte (855-463-3463 or medinfo@incyte.com)<sup>1,2</sup>
- **Expanded-access program** (NCT04355793) available for emergency treatment of cytokine storm from COVID-19 infection in adults and pediatric patients ≥12 years of age; address inquiries to Incyte (855-463-3463 or medinfo@incyte.com)<sup>3</sup>
- Other earlier-phase, smaller, and/or open-label clinical trials registered:
  - NCT04331665
  - NCT04334044
  - NCT04338958
  - NCT04348071
  - NCT04359290
  - NCT04354714
  - NCT04348695
  - ChiCTR2000029580 (in Chinese Clinical Trial Registry)<sup>3,6</sup>

**Dosage**: Various dosages are being evaluated<sup>3,6,10</sup> Phase 3 study (NCT04362137): Ruxolitinib 5 mg twice daily for 14 days with possible extension to 28 days<sup>10</sup>
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| Sarilumab (Kefzara\(®\))  
*Updated 5/1/20* | 92:36 Disease-modifying Anti-rheumatic Drug | Recombinant humanized monoclonal antibody specific for the interleukin-6 (IL-6) receptor; may potentially combat cytokine release syndrome (CRS) and pulmonary symptoms in severely ill patients \(^1\) \(^4\) \(^6\) | Currently no known published clinical trial evidence supporting efficacy or safety in treatment of patients with COVID-19  
However, based on encouraging results in China with a similar drug, tocilizumab, a U.S.-based, phase 2/3, randomized, double-blind, placebo-controlled study evaluating efficacy and safety of sarilumab in patients hospitalized with severe COVID-19 is currently under way  
For compassionate use access or investigator-sponsored clinical studies, contact the manufacturer (Sanofi Genzyme) for further information (1-800-633-1610) \(^6\) | Not available (see Trials or Clinical Experience) | NIH COVID-19 Treatment Guidelines Panel states that there are insufficient clinical data to recommend either for or against use of sarilumab in the treatment of COVID-19 \(^7\) |
| Siltuximab (Sylvant\(®\))  
*Added 5/13/20* | 10:00 Antineoplastic agents | Recombinant chimeric monoclonal antibody specific for the interleukin-6 (IL-6) receptor; may potentially combat cytokine release syndrome (CRS) symptoms (e.g., fever, organ failure, death) in severely ill patients \(^1\) \(^4\) \(^6\) | Italy: Early (non-peer-reviewed) findings from an observational case-control study of the first 21 patients with COVID-19 and pneumonia/acute respiratory distress syndrome (ARDS) who participated in a compassionate use program (SISCO study; NCT04322188) in one hospital and were followed for up to 7 days showed reduced and normalized C-reactive protein (CRP) levels (a marker of systemic inflammation) by day 5 in all 16 siltuximab-treated patients with sufficient available data. An interim analysis revealed that the condition of 33% of the siltuximab-treated patients improved and no clinically relevant change in condition was reported in 43% of patients while 24% of patients worsened, including one patient who died and another with a cerebrovascular event. This cohort study with patients treated with standard therapy is ongoing. \(^4\) \(^6\)  
Other clinical trials evaluating siltuximab in the treatment of COVID-19 currently are recruiting in Belgium (NCT04330638) \(^7\) and Spain (NCT04329650) \(^6\) | In the SISCO study in Italy, patients received an initial dose of siltuximab 11 mg/kg by IV infusion over 1 hour; a second dose could be administered at the physician’s discretion (5 of the first 21 patients received a second dose after 2-3 days) \(^6\)  
Other clinical studies under way are evaluating a single siltuximab dose of 11 mg/kg by IV infusion \(^7\) \(^8\) | Efficacy and safety of siltuximab in the treatment of COVID-19 not established; additional study needed |
| Sirolimus (Rapamune\(®\))  
*Updated 5/28/20* | 92:44 Immunosuppressive agent (mTOR inhibitor)  
In vitro studies demonstrated inhibitory activity | Clinical trials evaluating sirolimus for the treatment of COVID-19 are planned or underway including the following trials: \(^4\)  
NCT04341675  
NCT04341675  
NCT04347903  
NCT04371640  
Dosage being investigated in a randomized, double-blind, placebo-controlled trial (NCT04341675): 6 mg orally on day 1 followed by 2 mg daily for a maximum treatment duration of 14 days or until hospital discharge \(^8\) | Although possible clinical application, current data not specific to COVID-19; additional study needed \(^7\) |
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<th>Trials or Clinical Experience</th>
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<td>Tocilizumab (Actemra®)</td>
<td>92:36 Disease-modifying Anti-rheumatic Drug</td>
<td>Recombinant humanized monoclonal antibody specific for the interleukin-6 (IL-6) receptor; may potentially combat cytokine release syndrome (CRS) symptoms in severely ill COVID-19 patients $^1$-$^3$, $^6$, $^10$, $^{14}$</td>
<td>Case reports and observational studies describing use of tocilizumab in patients with COVID-19 reported from various areas of the world $^1$-$^3$, $^10$, $^{12}$ In preliminary data from a non-peer-reviewed, single-arm, observational Chinese trial (Xu et al.) involving 21 patients with severe or critical COVID-19 infection, patients demonstrated rapid fever reduction and a reduced need for supplemental oxygen within several days after receiving tocilizumab (initially given as a single 400-mg dose by IV infusion; this dose was repeated within 12 hours in 3 patients because of continued fever) $^3$ In a retrospective, observational study in China (Luo et al.) involving 15 patients moderately to critically ill with COVID-19, tocilizumab (80-600 mg per dose) was given, and was used in conjunction with methylprednisolone in 8 of the patients. About one-third of the patients received 2 or more doses of tocilizumab. Elevated C-reactive protein (CRP) levels rapidly decreased in most patients following treatment, and a gradual decrease in IL-6 levels was noted in patients who stabilized following tocilizumab administration. Clinical outcomes were equivocal. $^{10}$ A single-center, retrospective observational study of 20 kidney transplant recipients in Italy with COVID-19 hospitalized for pneumonia included 6 patients who received tocilizumab. Half of the patients experienced reduced oxygen requirements and</td>
<td>IV infusion: China recommends an initial dose of 4–8 mg/kg infused over more than 60 minutes. If initial dose not effective, may administer second dose (in same dosage as initial dose) after 12 hours. No more than 2 doses should be given; maximum single dose is 800 mg $^2$ US/Global randomized, placebo-controlled trial (manufacturer sponsored; COVACTA): Will evaluate an initial IV infusion of 8 mg/kg (up to a maximum dose of 800 mg); one additional dose may be given if symptoms worsen or show no improvement $^8$</td>
<td>In China, tocilizumab can be used to treat severely or critically ill COVID-19 patients with extensive lung lesions and high IL-6 levels $^2$ NIH COVID-19 Treatment Guidelines Panel states that there are insufficient clinical data to recommend either for or against use of tocilizumab in the treatment of COVID-19 $^9$ The role of routine cytokine measurements (e.g., IL-6, CRP) in determining the severity of and treating COVID-19 requires further study $^{14}$</td>
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<td>2 (33%) showed improved radiologic findings following administration; 2 (33%) of the 6 tocilizumab-treated patients died. 12</td>
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<td>Zhang et al. from China reported on a patient with COVID-19 and multiple myeloma who appeared to be successfully treated with tocilizumab 13</td>
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<td>Currently, there are no well-controlled published studies on the efficacy and safety of tocilizumab for the treatment of COVID-19; however, numerous clinical trials are planned or under way globally 1, 5, 7, 8</td>
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<td>US/Global randomized, placebo-controlled trial: Manufacturer (Roche) conducting a randomized, double-blind, placebo-controlled phase 3 trial (COVACTA; NCT04320615) in collaboration with the US Health and Human Services’ Biomedical Advanced Research and Development Authority (BARDA); the study will evaluate safety and efficacy of tocilizumab in combination with standard of care compared with placebo. Expected to enroll about 330 patients globally, including in the U.S., beginning in April 2020 7, 8</td>
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### OTHER

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<td>ACE Inhibitors, Angiotensin II Receptor Blockers (ARBs)</td>
<td>24:32 Renin-Angiotensin-Aldosterone System Inhibitor</td>
<td><strong>Hypothetical harm:</strong> Human pathogenic coronaviruses bind to their target cells through angiotensin-converting enzyme 2 (ACE2).1, 4, 5 Expression of ACE2 may be increased in patients treated with ACE inhibitors or ARBs.1, 4, 5 Increased expression of ACE2 may potentially facilitate COVID-19 infections.6</td>
<td>Data are lacking; no evidence of harm or benefit with regards to COVID-19 infection.1, 2, 3 Clinical trial underway: Initiation of losartan in adult patients with COVID-19 requiring hospitalization; primary outcome measure: sequential organ failure assessment (SOFA) respiratory score. (NCT04312009)</td>
<td></td>
<td>American Heart Association (AHA), American College of Cardiology (ACC), Heart Failure Society of America (HFSA), European Society of Cardiology (ESC) recommend to continue treatment with renin-angiotensin-aldosterone system (RAAS) antagonists in those patients who are currently prescribed such agents.1, 7, 8 NIDK COVID-19 Treatment Guidelines Panel states patients who are receiving an ACE inhibitor or ARB for cardiovascular disease (or other indications) should continue receiving these drugs; recommends against use of ACE inhibitors or ARBs for the treatment of COVID-19 except in the context of a clinical trial.9 Patients with cardiovascular disease are at an increased risk of serious COVID-19 infections.1, 4 Abrupt withdrawal of RAAS inhibitors in high-risk patients (e.g., heart failure patients, patients with prior myocardial infarction) may lead to clinical instability and adverse health outcomes.8</td>
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<td>Anticoagulants (low molecular weight heparin [LMWH], unfractionated heparin [UFH])</td>
<td>20:12.04.16 Heparins</td>
<td>Patients with COVID-19, particularly those with severe disease, may develop a hypercoagulable state, which has been associated with poor outcomes (e.g., progressive respiratory failure, acute respiratory distress syndrome [ARDS], death).1, 6, 14, 16, 28, 29 Coagulation abnormalities observed include prothrombotic disseminated intravascular coagulation (DIC), VTE, elevated D-dimer levels, high fibrinogen levels, and microvascular and macrovascular thrombosis.1, 6, 8, 11, 16, 18</td>
<td>Limited data from a retrospective study in China showed reduced mortality in COVID-19 patients with severe sepsis-induced coagulopathy or markedly elevated D-dimer levels (&gt;6 x ULN) who received prophylactic anticoagulation (LMWH or UFH).4, 19 Several prospective, randomized open-label studies (NCT04373707, NCT04372589, NCT04345848) are being conducted to evaluate prophylactic- and therapeutic-dose anticoagulation in hospitalized adults with severe COVID-19 infection.12</td>
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<td>Additional study is needed to understand the anticoagulant needs of COVID-19 patients.1, 7, 11, 27, 28, 29 Several organizations have published interim guidance for the management of COVID-19-associated coagulopathy.4, 5, 9, 25, 27, 28, 30 The NIH COVID-19 Treatment Guideline Panel states that all hospitalized adults with COVID-19 should receive VTE prophylaxis according to the usual standard of care in patients without COVID-19 unless contraindicated.18 The International Society for Thrombosis and Haemostasis, American College of Cardiology, and American Society of Hematology recommend that all hospitalized COVID-19 patients receive</td>
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<td>True incidence of these complications not known, but have varied in patients with different severities of disease. 28</td>
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<td>prophylactic-dose LMWH unless contraindicated (e.g., active bleeding, severe thrombocytopenia, fibrinogen &lt;0.5 g/L). 4, 5, 30</td>
<td>WHO recommends pharmacologic prophylaxis with LMWH (preferred) or UFH (5000 units sub-Q twice daily) in adults and adolescents with COVID-19 who do not have contraindications. 25</td>
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<td>Pathogenesis of COVID-19-related coagulopathy not completely known, but may be related to inflammatory response to viral infection. 16, 17, 27-29</td>
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<td>LMWH or UFH may be preferred over oral anticoagulants in critically ill hospitalized patients with COVID-19 because of their shorter half-lives, ability to be administered parenterally, and fewer drug-drug interactions. 28 Practical concerns (e.g., need for frequent monitoring, convenience of administration, risk of medical staff exposure) may influence institutional choice of anticoagulant. 8, 9, 14, 20, 27</td>
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<td>Anticoagulant therapy may reduce the risk of thrombotic complications and improve clinical outcomes. 2, 4, 5, 14, 25, 27</td>
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<td>Because of the severity of coagulopathy in critically ill COVID-19 patients and reports of high rates of VTE despite standard prophylaxis, some clinicians have suggested the use of higher prophylactic doses or even therapeutic doses of anticoagulants to prevent thrombotic events in patients with COVID-19; however, high-quality prospective studies are needed to evaluate these approaches. 11, 14, 17, 20-24, 28, 17, 28, 30</td>
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<td>An additional benefit of heparins is their anti-inflammatory effects. 5, 7, 8, 17</td>
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<td>Pending additional data, it is recommended that use of higher-intensity nonstandard VTE prophylaxis or therapeutic anticoagulation should ideally be done in the context of a clinical trial. 28, 30</td>
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The NIH COVID-19 Treatment Panel and other experts state that the current data are insufficient to recommend for or against the use of therapeutic anticoagulation in COVID-19 patients in the absence of confirmed or suspected thrombosis. 4, 28, 30 The efficacy of intermediate or full therapeutic anticoagulation for critically ill COVID-19 patients without documented VTE is currently
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| COVID-19     |            |                                                                           |                                                                                                 |               | being evaluated. Patients who are already on anticoagulant therapy for an existing condition (e.g., VTE, atrial fibrillation) should continue to receive such treatment unless significant bleeding occurs or other contraindications are present.  

The NIH Panel states that routine post-hospitalization VTE prophylaxis is not recommended for COVID-19 patients. However, based on demonstrated benefits in certain high-risk patients without COVID-19, extended VTE prophylaxis may be considered in selected COVID-19 patients based on an individual assessment of risks versus benefits. The risk of VTE and anticoagulation requirements should be assessed in all patients on an individual basis. However, standard risk factors for bleeding should be considered and patients should be individually assessed to balance risk of thrombosis with risk of bleeding.  

Bleeding appears to be infrequent in COVID-19 patients. However, standard risk factors for bleeding should be considered and patients should be individually assessed to balance risk of thrombosis with risk of bleeding.  


The NIH COVID-19 Treatment Guideline Panel states that there are insufficient data to recommend for or against the use of convalescent plasma in patients with COVID-19. Appropriate criteria for selection of patients to receive investigational COVID-19 convalescent plasma, optimal time during the course of the disease to receive such therapy, and appropriate dosage (e.g., volume, number of doses) not determined. Theoretically, convalescent plasma should be more effective if given during the early course of the disease. Optimal timing of donor plasma collection in relation to recovery from

| COVID-19 Convalescent Plasma |            | Plasma obtained from patients who have recovered from COVID-19 (i.e., COVID-19 convalescent plasma) that contains antibodies against SARS-CoV-2 may provide short-term passive immunity to the virus; theoretically, such immunity may prevent or contribute to recovery from the infection, possibly as the result of viral neutralization and/or other mechanisms. |
|                            |            | Uncontrolled pilot study of COVID-19 convalescent plasma in China: 10 adults with severe COVID-19 received a single transfusion of COVID-19 convalescent plasma (containing SARS-CoV-2 neutralizing antibody titers of 1:640 or greater) with standard care; all patients received antiviral therapy (e.g., umifenovir [Arbidol®], ribavirin, oseltamivir, peramivir, interferon α) and 6 patients also received methylprednisolone. The median time from onset of symptoms to transfusion of convalescent plasma was 16.5 days. COVID-19 symptoms (fever, cough, shortness of breath, chest pain) improved in all patients within 1-3 days after the transfusion and all patients showed radiologic improvement in pulmonary lesions. Titer of neutralizing antibody increased in 5 patients after the transfusion, but remained the same in 4 patients. Prior to the transfusion, RT-PCR tests for SARS-CoV-2 RNA were positive in 7 patients. | Efficacy and safety of COVID-19 convalescent plasma for the treatment of COVID-19 not established.  

The NIH COVID-19 Treatment Guideline Panel states that there are insufficient data to recommend for or against the use of convalescent plasma in patients with COVID-19.  

Appropriate criteria for selection of patients to receive investigational COVID-19 convalescent plasma, optimal time during the course of the disease to receive such therapy, and appropriate dosage (e.g., volume, number of doses) not determined.  

Theoretically, convalescent plasma should be more effective if given during the early course of the disease.  

Optimal timing of donor plasma collection in relation to recovery from

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<td>In patients with SARS-CoV-1 infection, use of convalescent plasma was reported to shorten the duration of hospitalization and decrease mortality; 6,8,14 SARS patients who received convalescent plasma less than 14 days after onset of symptoms had better outcomes than those who received such plasma later in the course of the disease. 1, 2, 6, 8 and negative in 3 patients; after transfusion, SARS-CoV-2 RNA was undetectable in 3 patients on day 2, 3 patients on day 3, and 1 patient on day 6. 9</td>
<td>Uncontrolled case series in China: 5 critically ill adults with rapidly progressing severe COVID-19 and acute respiratory distress syndrome (ARDS) requiring mechanical ventilation who had high viral loads despite antiviral treatment received 2 transfusions of COVID-19 convalescent plasma (containing SARS-CoV-2 neutralizing antibody end point dilution titers of 80-480 depending on the donor); patients continued to receive antiviral treatments (e.g., LPV/RTV, favipiravir, umifenovir [Arbidol®], darunavir, interferon α-1b) and methylprednisolone. Patients received the convalescent plasma transfusions 10-22 days after hospital admission. Following the transfusions, body temperature normalized within 3 days in 4/5 patients, sequential organ failure assessment (SOFA) scores improved in all patients (decreased from initial scores of 2-10 to 1-4 on day 12), titers of SARS-CoV-2 IgG, IgM, and neutralizing antibody increased in all patients, and viral loads decreased and became negative within 12 days. 10</td>
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<td>Retrospective observational study in China: 6 critically ill adults with COVID-19 were treated with convalescent plasma at a median of 21.5 days after first detection of viral shedding. Although viral clearance was observed in all patients following transfusion, death occurred in 5 of 6 patients. 16</td>
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<td>Uncontrolled descriptive study in China: 6 adults with COVID-19 received convalescent plasma initiated at a relatively late stage of the disease (most patients received 2 or 3 plasma transfusions); various laboratory, radiologic, and clinical improvements were reported. 18</td>
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<td>Although there is some evidence that suggests possible benefits from use of convalescent plasma in patients with COVID-19, available data to date are largely from case reports or series; confirmation from</td>
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<td>COVID-19, most appropriate methods of antibody testing, and minimum titers of SARS-CoV-2 antibody in convalescent plasma that may be associated with clinical benefits in pts with COVID-19 not determined. 1-6</td>
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<td>Logistics of obtaining, processing, storing, and distributing COVID-19 convalescent plasma evolving. 1-5, 11, 14, 15 FDA does not collect COVID-19 convalescent plasma and does not provide such plasma; healthcare providers and acute care facilities obtain COVID-19 convalescent plasma from FDA-registered establishments. 11</td>
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<td>Potential risks associated with COVID-19 convalescent plasma therapy (e.g., inadvertent transmission of other infectious agents, allergic reactions, thrombotic complications, transfusion-associated circulatory overload, transfusion-related acute lung injury [TRALI], antibody-dependent enhancement of infection) and steps to mitigate such risks not fully determined and require further evaluation. 1-5, 9, 23, 24, 25</td>
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<td>FDA issued a guidance for industry to provide recommendations to healthcare providers and investigators regarding administration and study of investigational COVID-19 convalescent plasma. This guidance document includes recommendations regarding pathways for access to COVID-19 convalescent plasma, patient eligibility to receive such plasma, collection of such plasma (including donor eligibility and qualifications), product labeling, and recordkeeping. 11</td>
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<td>There are no convalescent blood products currently licensed by the FDA. 25 COVID-19 convalescent plasma is regulated as an investigational product. 11 FDA states that there are 3 available pathways for administering or studying the use of such plasma:</td>
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<td>randomized controlled studies is required. 1, 20-23</td>
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**Multiple clinical trials have been initiated in the US and other countries** to evaluate use of COVID-19 convalescent plasma in various settings (e.g., postexposure prophylaxis, treatment of different stages of the disease). 19,22 Some of the trials that are currently recruiting are listed below. For additional trials, see clinicaltrials.gov:

- NCT04374370 (Expanded Access)
- NCT04358211 (Expanded Access)
- NCT04338360 (Expanded Access)
- NCT04363034 (Expanded Access)
- NCT04343261 (US)
- NCT04372368 (US)
- NCT04343755 (US)
- NCT0434535 (US)
- NCT04364737 (US)
- NCT04340050 (US)
- NCT04344015 (US)
- NCT04360486 (US ARMY)
- NCT04347681
- NCT04346446
- NCT04345523
- NCT04342182
- NCT04352751
- NCT04375098
- NCT04357106
- NCT04327349
- NCT04292340

1). **Clinical Trials:** Requests to study use of COVID-19 convalescent plasma should be submitted to FDA under the traditional investigational new drug (IND) regulatory pathway. 11

2). **Expanded Access IND:** For patients with serious or immediately life-threatening COVID-19 who are not eligible or are unable to participate in randomized clinical trials, an expanded access IND can be used. A National Expanded Access Treatment Protocol has been established to facilitate access through participation of acute care facilities under an IND that is already in place. 11 Information on a protocol that is currently in place is available at [https://www.uscovidplasma.org](https://www.uscovidplasma.org). 12

3). **Single Patient Emergency IND (eIND):** Licensed physicians seeking to administer COVID-19 convalescent plasma to individual patients with serious or life-threatening disease may request an eIND from the FDA. Consult the FDA guidance document for specific information on applying for an eIND. 11

**Donor eligibility:** FDA guidance suggests that COVID-19 convalescent plasma be collected from individuals with laboratory-confirmed evidence of COVID-19 infection and complete resolution of symptoms for at least 14 days before donation (a negative result for COVID-19 by a diagnostic test is not necessary to qualify the donor). 11

**Antibody titers in donor plasma:** If measurement of antibody titers is available, FDA recommends a neutralizing antibody titer of at least 1:160 (a titer of 1:80 may be considered acceptable if an alternative matched unit of plasma is not available). 11

**Patient eligibility:** For healthcare providers seeking an eIND for the treatment of patients with severe or life-threatening disease, consideration should be given to following the patient eligibility criteria used in the National Expanded Access Treatment Protocol.
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<tr>
<td>Famotidine</td>
<td>56:28.12</td>
<td>Histamine H₂ Antagonists</td>
<td>Computer-aided, structure-based, virtual screening of libraries of compounds against SARS-CoV-2 proteins suggested potential for famotidine to interact with viral proteases involved in coronavirus replication.</td>
<td>Currently no known published prospective clinical trial evidence supporting efficacy or safety for treatment of COVID-19. Randomized, double-blind, historical-controlled, comparative trial (NCT04370262) initiated in New York in hospitalized adults with moderate to severe COVID-19; trial includes 2 active treatment groups (high-dose IV famotidine with oral hydroxychloroquine, IV placebo with oral hydroxychloroquine) and a historical control group receiving neither of these drugs (patients treated during early stages of the COVID-19 pandemic in New York); targeted enrollment is 600 patients in each active treatment group; 2 interim analyses planned.</td>
<td>Safety and efficacy for treatment of COVID-19 not established.</td>
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<td>HMG-CoA Reductase Inhibitors (statins)</td>
<td>24:06 Antilipemic Agents</td>
<td>In addition to lipid-lowering effects, statins have anti-inflammatory and immunomodulatory effects which may prevent acute lung injury. Statins affect ACE2 as part of their function in reducing endothelial dysfunction.</td>
<td>Data are lacking on the use of statins in patients with COVID-19. Preliminary findings have shown mixed results with other respiratory illnesses; some observational studies suggest statin therapy is associated with a reduction in various cardiovascular outcomes and possibly mortality in patients hospitalized with influenza and/or pneumonia. Clinical trials are evaluating the effectiveness of statins (with and without other potential treatment agents) for the treatment of COVID-19. (NCT04333407)</td>
<td>NIH COVID-19 Treatment Guidelines Panel states patients who are receiving a statin for the treatment or prevention of cardiovascular disease should continue statin therapy; recommends against use of statins for the treatment of COVID-19 except in the context of a clinical trial.</td>
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<td>Immune Globulin</td>
<td>80:04 Immune Globulin</td>
<td>Commercially available immune globulin (IGIV, IVIG, γ-globulin) is derived from pooled plasma and contains many antibodies normally present in adult human blood; used for replacement therapy in patients with primary humoral immunodeficiency who are unable to produce sufficient IgG antibodies and also used to provide passive immunity to certain viral infections in other individuals. Investigational SARS-CoV-2 immune globulin is a</td>
<td>SARS Experience: IGIV has been used in the treatment of SARS. Benefits were unclear because of patient comorbidities, differences in stage of illness, and effect of other treatments. IGIV may have contributed to hypercoagulable state and thrombotic complications in some patients. COVID-19 case reports in China (Cao et al): Treatment with IGIV at the early stage of clinical deterioration was reported to provide some clinical benefit in 3 adults with severe COVID-19; 2 patients also received antivirals and 1 patient also received short-term steroid treatment. Patients were afebrile within 1-2 days and breathing difficulties gradually improved within 3-5 days of IGIV administration.</td>
<td>IGIV dosage of 0.3-0.5 g/kg daily for 5 days has been used in some patients with COVID-19. Role of commercially available immune globulin (IGIV, IVIG, γ-globulin) and investigational SARS-CoV-2 immune globulin in the treatment of COVID-19 unclear. The Surviving Sepsis Campaign COVID-19 subcommittee suggests that IGIV not be used routinely in critically ill adults with COVID-19 because efficacy data not available, currently available IGIV preparations may not contain antibodies against SARS-CoV-2, and IGIV can be associated with increased risk of severe adverse effects (e.g., anaphylaxis, aseptic meningitis, renal failure, thromboembolism, hemolytic reactions, transfusion-related lung injury).</td>
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<td>concentrated immune globulin preparation containing specific antibody derived from the plasma of individuals who have recovered from COVID-19. 16</td>
<td></td>
<td></td>
<td>COVID-19 clinical experience in China: IGIV has been used as an adjunct in the treatment of COVID-19 and has been mentioned in Chinese guidelines as a possible treatment option for severe and critically ill children with COVID-19. 9-11, 14</td>
<td></td>
<td>The NIH COVID-19 Treatment Guideline Panel recommends against the use of commercially available IGIV (i.e., non-SARS-CoV-2-specific IGIV) for the treatment of COVID-19 except in the context of a clinical trial and states that current IGIV preparations are not likely to contain SARS-CoV-2 antibodies. 13 This does not preclude the use of IGIV when it is otherwise indicated for the treatment of complications arising during the course of COVID-19 disease. 16 The NIH Treatment Panel states that there are insufficient data to recommend for or against the use of investigational SARS-CoV-2 immune globulin for the treatment of COVID-19. 16</td>
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<td>Ivermectin</td>
<td>Anthelmintic</td>
<td>In vitro activity against some human and animal viruses 1-6</td>
<td>Currently no known published data regarding efficacy or safety in the treatment of COVID-19</td>
<td></td>
<td>No data to date to support use in the treatment of COVID-19 Ivermectin plasma concentrations attained with dosages recommended for treatment of parasitic infections are substantially lower than concentrations associated with in vitro inhibition of SARS-CoV-2; 7,9 pharmacokinetic modeling predicts that plasma concentrations attained with dosages up to 10 times higher than usual dosage also are substantially lower than concentrations associated with in vitro inhibition of the virus 9 FDA issued a warning concerning possible inappropriate use of ivermectin products intended for animals as an attempt to self-medicate for the treatment of COVID-19 8</td>
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<tr>
<td>Updated 5/15/20</td>
<td></td>
<td>In vitro evidence of activity against SARS-CoV-2 in infected Vero-hSLAM cells reported with high concentrations of the drug 1</td>
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<td>Nebulized drugs Added 3/27/20</td>
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<td>Potential harm: Concern that use of nebulized drugs (e.g., albuterol) for the management of respiratory conditions in patients with COVID-19 infection may distribute the virus into the air and expose close contacts.</td>
<td>Nebulizer treatment used in clinical practice to treat influenza and other respiratory infections is thought to generate droplets or aerosols. In one study, nebulized saline delivered droplets in the small- and medium-size aerosol/droplet range. These results may have infection control implications for airborne infections, including severe acute respiratory syndrome and pandemic influenza infection.</td>
<td></td>
<td>American College of Allergy, Asthma &amp; Immunology (ACAAI) recommends that nebulized albuterol should be administered in a location that minimizes exposure to close contacts who do not have COVID-19 infection. In the home, choose a location where air is not recirculated (e.g., porch, patio, or garage) or areas where surfaces can be cleaned easily or may not need cleaning. In hospitals, clinicians typically use nebulizers to deliver medications such as albuterol, but are being encouraged to switch to use of metered-dose inhalers because of the risk of the virus becoming airborne when treating patients infected with COVID-19.</td>
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<td>Niclosamide Updated 5/28/20</td>
<td>8:08 Anthelmintic</td>
<td>Broad antiviral activity In vitro evidence of activity against SARS-CoV and MERS-CoV</td>
<td>Currently no known published clinical trial data regarding efficacy or safety in the treatment of COVID-19 In drug repurposing screens, was found to inhibit replication and antigen synthesis of SARS-CoV; did not interfere with virion’s attachment into cells Randomized, open-label, controlled trial in France (NCT04372082; HYdILIC) to evaluate niclosamide in adults with SARS-CoV-2 infection (asymptomatic or onset of symptoms less than 8 days previously) and comorbidities Randomized, double-blind placebo-controlled trial in Boston, (NCT04399356) to evaluate niclosamide in adults with mild to moderate COVID-19</td>
<td>Protocol in one ongoing trial (NCT04372082) for treatment of COVID-19 specifies a niclosamide dosage of 2 g on day 1, then 500 mg twice daily for 10 days Protocol in one ongoing trial (NCT04399356) for treatment of mild to moderate COVID-19 specifies a dosage of 2 g once daily for 7 days</td>
<td>Not commercially available in the US No data to date support use in treatment of COVID-19</td>
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<tr>
<td>Nitazoxanide Updated 5/28/20</td>
<td>8:30.92 Antiprotozoal</td>
<td>In vitro activity against various viruses, including coronaviruses Structurally similar to niclosamide In vitro evidence of activity against SARS-CoV-2 In vitro activity against MERS-CoV</td>
<td>Currently no known published clinical trial data regarding efficacy or safety in the treatment of COVID-19 Experience in treating influenza: In a randomized, placebo-controlled study in 624 otherwise healthy adult and adolescent patients with acute uncomplicated influenza, treatment with nitazoxanide reduced duration of symptoms by approximately 1 day Dosages investigated for treatment of influenza and influenza-like illness or being investigated for other viral infections: Adults and adolescents (≥12 years of age): 500 or 600 mg orally twice daily for 5 days Protocol in one ongoing trial (NCT04348409) for treatment of moderate COVID-19 specifies a nitazoxanide dosage of 600 mg twice daily for 7 days</td>
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<td>Current data not specific to COVID-19; additional study needed</td>
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<td><strong>Nitazoxanide</strong></td>
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<td>Suppresses production of proinflammatory cytokines in peripheral blood mononuclear cells; suppresses IL-6 in mice</td>
<td>Experience in treating influenza-like illness: In two studies for the treatment of influenza-like illness symptoms associated with viral respiratory infection in 186 adults and pediatric pts, treatment with nitazoxanide reduced duration of symptoms (4 days versus ≥7 days with placebo). In another study in 260 adults and pediatric pts hospitalized with influenza-like illness (≥50% with pneumonia at presentation), treatment with nitazoxanide did not reduce the duration of hospital stay (primary end point) or duration of symptoms. <strong>COVID-19</strong>: Randomized, double-blind, placebo-controlled proof-of-concept trial (NCT04348409) initiated to evaluate nitazoxanide for treatment of moderate COVID-19. Two randomized, double-blind, placebo-controlled clinical trials have been initiated by the manufacturer (Romark) to evaluate efficacy and safety for pre- or post-exposure prophylaxis of COVID-19 and other viral respiratory illnesses in healthcare workers (NCT04359680) and post-exposure prophylaxis of COVID-19 and other viral respiratory illnesses in elderly residents of long-term care facilities (NCT04343248). Multiple other clinical trials planned or initiated to evaluate nitazoxanide in combination with other drugs (chloroquine, hydroxychloroquine, or ivermectin) or alone for treatment of COVID-19. Protocol in two ongoing trials (NCT04343248,NCT04359680) evaluating pre- and/or post-exposure prophylaxis of COVID-19 and other viral respiratory illnesses specifies a nitazoxanide dosage of 600 mg orally twice daily for 6 weeks. Results of a physiologically based pharmacokinetic model predict that nitazoxanide dosages of 1200 mg 4 times daily, 1600 mg 3 times daily, and 2900 mg twice daily in the fasted state and 700 mg 4 times daily, 900 mg 3 times daily, and 1400 mg twice daily in the fed state are capable of maintaining plasma and lung nitazoxanide (major metabolite of nitazoxanide) exposures exceeding the EC90 for SARS-CoV-2.</td>
<td>Protocol in two ongoing trials (NCT04343248,NCT04359680) evaluating pre- and/or post-exposure prophylaxis of COVID-19 and other viral respiratory illnesses specifies a nitazoxanide dosage of 600 mg orally twice daily for 6 weeks. Results of a physiologically based pharmacokinetic model predict that nitazoxanide dosages of 1200 mg 4 times daily, 1600 mg 3 times daily, and 2900 mg twice daily in the fasted state and 700 mg 4 times daily, 900 mg 3 times daily, and 1400 mg twice daily in the fed state are capable of maintaining plasma and lung nitazoxanide (major metabolite of nitazoxanide) exposures exceeding the EC90 for SARS-CoV-2.</td>
<td><strong>Nonsteroidal Anti-inflammatory Agents (NSAIAs)</strong></td>
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<td><strong>Ibuprofen</strong></td>
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<td>Speculative link between ibuprofen and increased ACE2 expression leading to worse outcomes in COVID-19 patients, and should NOT be used in patients with COVID-19.</td>
<td>Ibuprofen: None; anecdotal. <strong>Indomethacin</strong>: In vitro antiviral activity in SARS-CoV-2 pseudovirus-infected Vero E6 cells; also has in vitro activity</td>
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<td>against other coronavirus-</td>
<td>website or other official sources. WHO has stated &quot;after a rapid review of the literature, is not aware of published clinical or population-based data on this topic.&quot; As of 3/18/20 (via Twitter) &quot;WHO does not recommend against the use of ibuprofen.&quot; <a href="https://twitter.com/WHO/status/1240409217997189128">https://twitter.com/WHO/status/1240409217997189128</a></td>
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<td>es: SARS-CoV-1 (in Vero E6 and human pulmonary epithelial [A549] cells) and canine coronavirus; also has in vivo activity against canine coronavirus in dogs (interferes with viral RNA synthesis) 6,7</td>
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<td>6, 7</td>
<td>In addition, there have been unsubstantiated reports of younger, healthy patients who took ibuprofen and suffered severe outcomes with COVID-19. Official case reports are lacking.</td>
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<td>On 3/19/20, FDA issued a statement that it is not aware of scientific evidence connecting the use of NSAIDs, such as ibuprofen, with worsening COVID-19 symptoms. FDA stated that it is investigating this issue further and will communicate publicly when more information is available. FDA also noted that all prescription NSAID labels warn that by reducing inflammation, and possibly fever, these drugs may diminish the utility of diagnostic signs in detecting infections. <a href="https://www.fda.gov/drugs/drug-safety-and-availability/fda-advises-patients-use-non-steroidal-anti-inflammatory-drugs-nsaids-covid-19">https://www.fda.gov/drugs/drug-safety-and-availability/fda-advises-patients-use-non-steroidal-anti-inflammatory-drugs-nsaids-covid-19</a></td>
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<td>Therefore, currently no compelling evidence to support an association between ibuprofen and negative outcomes in patients with COVID-19. However, some experts have recommended preferentially using acetaminophen for treatment of fever 2, 3, 4</td>
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<td>NIH COVID-19 Treatment Guidelines Panel states that patients who are receiving NSAIDs for other conditions should continue receiving the drugs; states antipyretic strategy (e.g., use of acetaminophen or NSAIDs) should be no different between patients with or without COVID-19. 5</td>
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<td>The Surviving Sepsis Campaign COVID-19 guidelines state that until more</td>
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<td>Tissue Plasminogen Activator (t-PA; alteplase)</td>
<td>20:12.20 Thrombolytic agents</td>
<td>A consistent finding in patients with severe COVID-19 is a hypercoagulable state, which may contribute to their risk of poor outcomes (e.g., progressive respiratory failure, acute respiratory distress syndrome [ARDS], death). Coagulation abnormalities observed in these patients include prothrombotic disseminated intravascular coagulation (DIC), a high incidence of venous thromboembolism, elevated D-dimer levels, high fibrinogen levels, and microvascular and macrovascular thrombosis. In patients with ARDS (regardless of the cause), pathologic findings include fibrin deposition in the alveoli and formation of microthrombi in the pulmonary vasculature. Treatment with t-PA may restore microvascular patency and limit progression of ARDS in patients with COVID-19.</td>
<td>Results of a small phase 1 study conducted in 2001 suggest possible benefit of plasminogen activators for the treatment of ARDS. In this study, 20 patients with ARDS secondary to trauma and/or sepsis who failed to respond to standard ventilator therapy and were not expected to survive were treated with urokinase or streptokinase; such therapy improved PaO(_2) and also appeared to improve survival. A registered open-label randomized trial (NCT04357730) will evaluate systemic fibrinolytic therapy with t-PA versus standard care in mechanically ventilated COVID-19 patients with severe respiratory failure. A registered open-label nonrandomized pilot study (NCT04356833) will evaluate an inhaled formulation of t-PA (via nebulization) in patients with ARDS due to COVID-19. The inhaled formulation of t-PA is investigational at this time.</td>
<td>The open-label systemic fibrinolytic therapy trial (NCT04357730) will evaluate t-PA (alteplase) dosages of 50 mg (administered as a 10-mg IV bolus followed by IV administration of the remaining 40 mg over a total time of 2 hours) and 100 mg (administered as a 10-mg IV bolus dose followed by IV administration of the remaining 90 mg over a total time of 2 hours); a heparin infusion will be initiated immediately following completion of the alteplase infusion. Other dosage regimens have been evaluated in patients with ARDS associated with COVID-19, including an initial t-PA (alteplase) dose of 25 mg administered IV over 2 hours, followed by an IV infusion of 25 mg of t-PA over the subsequent 22 hours, with a dose not to exceed 0.9 mg/kg (Beth Israel Deaconess et al study); however, the optimum dose, route of administration, and duration of treatment remain to be determined.</td>
<td>(t)-PA has been proposed as a salvage treatment for COVID-19 patients (e.g., those with decompensating respiratory failure), however, there are currently no clinical trial data to inform this practice and a lack of clinical experience with the use of fibrinolytic agents in ARDS patients in general. Several institutions (Beth Israel Deaconess, University of Colorado Anschutz Medical Campus, Denver Health) are currently testing the use of (t)-PA as salvage therapy in patients with severe COVID-19 under the FDA compassionate use program. Preliminary findings from the first few cases reported an initial, but transient improvement in PaO(_2)/FiO(_2) (P/F) ratio. The American Society of Hematology states that treatment of the underlying pathology is paramount in COVID-19 patients with coagulopathies; supportive care should be individualized and standard risk factors for bleeding should be considered.</td>
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\(^a\) See US prescribing information for additional information on dosage and administration of drugs commercially available in the US for other labeled indications.
ACE Inhibitors and Angiotensin II Receptor Blockers (ARBs)


Anakinra:

Anticoagulants
4. Ascorbic acid:


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Baloxavir:

Baricitinib:

Chloroquine and Hydroxychloroquine:

Chloroquine and Hydroxychloroquine as Available Weapons to Fight COVID-19:


35. US Food and Drug Administration. FDA drug safety communication: FDA cautions against use of hydroxychloroquine or chloroquine for COVID-19 outside of the hospital setting or a clinical trial due to risk of heart rhythm problems. April 24, 2020. Available at https://www.fda.gov/media/137250/download.


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Corticosteroids, including methylprednisolone:


Colchicine:


Corticosteroids, including methylprednisolone:


COVID-19 Convalescent Plasma:


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Epoprosotenol:


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Favipiravir

HIV Protease Inhibitors:


12. PMID: 10.1002/ddr.21666


15. PMID: 10.1378/chest.06-1997


20. The current version of this document can be found on the ASHP COVID-19 Resource Center.


**Interferons:**


Ivermectin:

Nebulized drugs:

Neuraminidase Inhibitors (e.g., oseltamivir):

Niclosamide:

Nitazoxanide:

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Nitric Oxide (inhaled):


NSAIDs, including ibuprofen:


Remdesivir:


Ruxolitinib

Sarilumab:

Siltuximab:

Sirolimus:
Tissue Plasminogen Activator (t-PA; alteplase):

1. Moore HB, Barrett CD, Moore EE et al. Is there a role for tissue plasminogen activator (tPA) as a novel treatment for refractory COVID-19 associated acute respiratory distress syndrome (ARDS)? J Trauma Acute Care Surg. DOI: 10.1097/TA.0000000000002694

Tocilizumab:


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Umifenovir:

The information contained in this evidence table is emerging and rapidly evolving because of ongoing research and is subject to the professional judgment and interpretation of the practitioner due to the uniqueness of each medical facility’s approach to the care of patients with COVID-19 and the needs of individual patients. ASHP provides this evidence table to help practitioners better understand current approaches related to treatment and care. ASHP has made reasonable efforts to ensure the accuracy and appropriateness of the information presented. However, any reader of this information is advised ASHP is not responsible for the continued currency of the information, for any errors or omissions, and/or for any consequences arising from the use of the information in the evidence table in any and all practice settings. Any reader of this document is cautioned that ASHP makes no representation, guarantee, or warranty, express or implied, as to the accuracy and appropriateness of the information contained in this evidence table and will bear no responsibility or liability for the results or consequences of its use.