The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Screening and Prescribing Form for Nirmatrelvir/Ritonavir (Paxlovid)

Pharmaceutical Services
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Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address

Section #1: Core Requirements

Indicate whether the patient meets the following criteria:

1. Currently an outpatient? ☐ Yes ☐ No
2. Covid-19 symptoms started within the last 5 days? ☐ Yes ☐ No
3. Patient had a positive Covid test (PCR or RAPT) within the past 5 days? ☐ Yes ☐ No
4. Is the patient a beneficiary of the NLPDP? ☐ Yes ☐ No

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If the answer is NO to any of the above questions, patient does not meet the NLPDP criteria.

If the answer is YES to all the above questions, proceed to Section #2.

Section #2: NLPDP Inclusion Criteria

Please check all boxes that apply:

Beneficiary has severe immunosuppression, such as:

- ☐ Recipient of solid organ transplant
- ☐ Treatment for a malignant hematologic condition
- ☐ Bone marrow, stem cell transplant, or transplant-related immunosuppressant use
- ☐ Receipt of an anti-CD20 drugs or B-cell depleting drugs (such as rituximab) in the past 2 years
- ☐ Severe primary immunodeficiencies

Beneficiary has moderate immunosuppression, such as:

- ☐ Treatment for cancer, including solid tumors
- ☐ Treatment with significantly immunosuppressing drugs (e.g., a biologic in the past 3 months, oral immune-suppressing medication in the past month, oral steroid [20mg/day of prednisone equivalent taken on an ongoing basis] in the past month, or immune-suppressing infusion or injection in the past 3 months). Specify drug name: _____
- ☐ Advanced HIV infection (treated or untreated)
- ☐ Moderate primary immunodeficiencies
- ☐ Renal conditions (i.e., hemodialysis, peritoneal dialysis, glomerulonephritis and dispensing of a steroid)

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If Section #1 requirements are met and at least one box is checked in Section #2, please proceed to Section #3

Section #3: Contraindications to Nirmatrelvir/Ritonavir

Indicate whether the patient:

1. Has a **severe hypersensitivity** to Nirmatrelvir or Ritonavir or excipients. ☐ Yes ☐ No
2. Has **severe hepatic impairment** (Child-Pugh Class C). ☐ Yes ☐ No
3. Has **severe renal impairment (GFR less than 30mL/min).** ☐ Yes ☐ No
   - o GFR and date collected (DD/MM/YYYY): _____
4. Is taking **medications that are contraindicated** for use with Nirmatrelvir/Ritonavir?
   - o If yes, please list medication(s): _____

- The following is a list of medications **contraindicated** for use with Nirmatrelvir/Ritonavir. It is a CYP3A inhibitor and substrate; therefore, may increase concentrations of other medications metabolized by CYP3A or may have a reduced concentration from strong CYP3A inducers: *Alfuzosin, ranolazine, amiodarone, bepridila, dronedarone, flecainide, propafenone, quinidine, fusidic acid, apalutamide, venetoclax, neratinib, rivaroxaban, carbamazepine, phenobarbital, phenytoin, voriconazole, colchicine, astemizole, terfenadine, rifampin, lurasidone, pimozide, dihydroergotamine, ergonovine, ergotamine, methylergonovine, cisapride, St. John's wort, lovastatin, simvastatin, lomitapide, salmeterol, sildenafil (only when used for the treatment of pulmonary arterial hypertension (PAH)), vardenafil (when used for the treatment of erectile dysfunction or PAH), orally administered midazolam, triazolam.*

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If **NO** to all the questions above, **PROCEED to Section #4**.

If **YES** to any of the above questions, the use of Nirmatrelvir/Ritonavir is **contraindicated. Treatment should not be offered**.

Section #4: Prescribing Details

Patient Name: _____ **MCP**: _____

Select Nirmatrelvir/Ritonavir **dose based on patient's GFR (that was provided in Section #3)**:

GFR greater than 60 mL/min:	**GFR between 30 and 60 mL/min:**
☐ Nirmatrelvir 300mg/ Ritonavir 100mg p.o.Q12H x 5 days	☐ Nirmatrelvir 150mg/ Ritonavir 100mg p.o. Q12H x 5 days

Prescriber Name: _____ Phone Number: _____ License Number: _____

Prescriber Signature: _____ Date (DD/MM/YYYY): _____

Note to Pharmacy and Prescribers:

The requirements of ALL Sections must be met to claim Nirmatrelvir/Ritonavir (Paxlovid) for NLPDP Beneficiaries.

This Screening and Prescribing Form is to be retained by pharmacy as it will serve as the official prescription and/or assessment and is subject to audit.

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