Clinical pathway: Therapies for patients hospitalised due to COVID-19

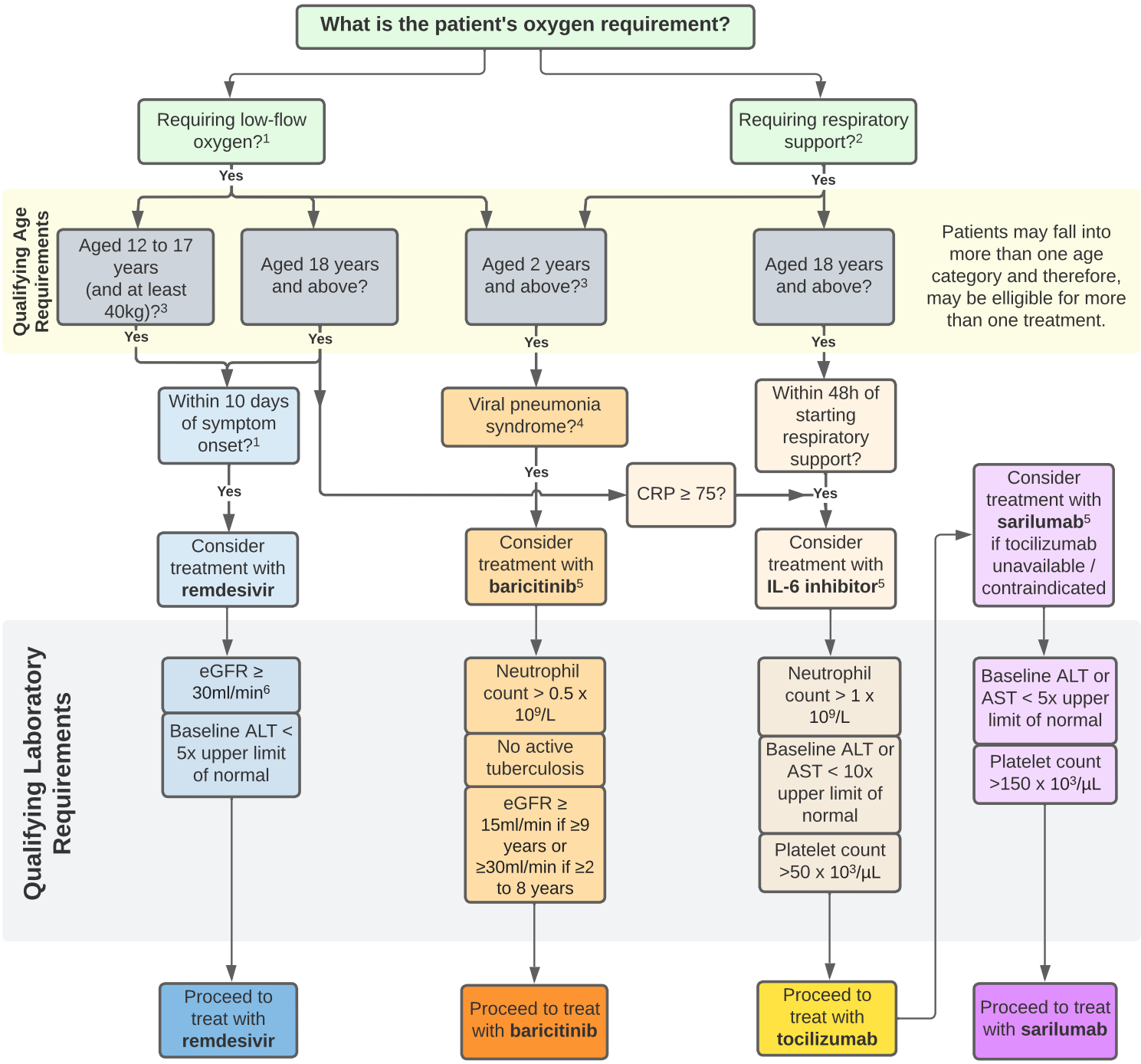
- This guide aims to support treatment decisions for commissioned COVID-19 therapies and outlines their position in the treatment pathway for patients hospitalised due to COVID-19. The relevant clinical commissioning policies should be consulted for further details
- Patients must be **hospitalised specifically for management of COVID-19** and must be **receiving supplemental oxygen or receiving respiratory support**
- Consult the relevant Summary of Product Characteristics for advice on contraception and use in pregnancy
- Please refer to the NICE COVID-19 Rapid Guideline (NG 191) for other treatments

CORTICOSTEROIDS

Consider dexamethasone (or hydrocortisone or prednisolone if treatment with dexamethasone is unavailable/not possible) in patients who require supplemental oxygen to maintain prescribed oxygen saturation levels

TRIALS

All **hospitalised** patients can consider joining the RECOVERY trial or the pandemic aspects of the REMAP-CAP trial. To enter RECOVERY, they should have: a **viral pneumonia syndrome**; confirmed **SARS-CoV-2 infection**; and no **medical history** that might put the patient at risk from entering a trial. To enter REMAP-CAP, they should be in critical care with an **acute illness due to suspected pandemic illness**. In addition any immunosuppressed patients on the ward or critical care can be considered for the convalescent plasma domain within REMAP-CAP. All patients in the trials should be included in the pathway of care described here. They can enter the trials at any stage in the care pathway.



Deterioration - Consider other therapeutic agent(s) from group above in accordance with respective clinical policies

[1] For treatment with remdesivir, the criteria relating to supplemental oxygen and the treatment window from symptom onset do not apply to significantly immunocompromised patients.
[2] Defined as: high-flow nasal oxygen, continuous positive airway pressure (CPAP) or non-invasive ventilation, or invasive mechanical ventilation.
[3] Clinicians should seek paediatric MDT advice for paediatric patients to determine clinical capacity to benefit from treatment.
[4] In general, viral pneumonia should be suspected when a patient presents with: a) typical symptoms (e.g. influenza-like illness with fever and muscle pain, or respiratory illness with cough and shortness of breath); AND b) compatible chest X-ray findings (consolidation or ground-glass shadowing); AND c) alternative causes have been considered unlikely or excluded (e.g. heart failure, bacterial pneumonia).
[5] Baricitinib should not routinely be co-administered with an IL-6 inhibitor (where co-administration means given simultaneously). However, in the situation of illness requiring critical care support or where a patient has deteriorated despite treatment, clinical judgement may deem co-administration appropriate. A patient may be additively given an IL-6 inhibitor after treatment with baricitinib has been commenced (or vice versa), according to clinical judgement.
[6] Patients with end-stage renal disease on haemodialysis are exempt from the specified eGFR threshold.

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