Version	Date	SIGNIFICANT REVISIONS (compared to previous)
V11	April 20, 2022	• Outpatient management: reference to "pre-emptive therapy" instead of "for monoclonal antibody or antiviral" • Decision tree for pre-emptive therapy: sotrovimab no longer recommended (not effective at neutralizing the BA2 variant of SARS-CoV2 (currently predominant strain in Quebec). Main offerings are now Paxlovid (po) or remdesivir IV x 3d. • Paxlovid to be prescribed by the treating (MRP) physician (ID-HOT not needed if there are no contraindications for this drug). Links to a drug interaction checker and to the MSSS template prescription (contains the required RAMQ codes) are provided • Remdesivir: ID-HOT needed to give first dose in Medical day (barring staffing issues), and doses 2 and 3 via CLSC • Inpatient management of COVID: ID no longer needs to approve Remdesivir prescriptions in mild or moderate disease • For severe disease: sarilumab replaced with baricitinib, because of paucity of data showing mortality benefit for sarilumab - baricitinib now the preferred alternative to tocilizumab if this product is unavailable. ID consult still required for severe disease • Footnotes updated.
V10	Jan 23, 2022	• Outpatient management: hyperlink to a decision tree for selection of candidates for Monoclonal antibody (Sotrovimab) vs oral antiviral (paxlovid) • Addition of paxlovid as an option (with pharmacy consultation) • Option of budesonide for outpatients not meeting criteria for MAb/paxlovid.

V9	Dec 21, 2021	• Remdesivir: recent evidence suggest it may have more benefit than initially thought (time to recovery and progression to severe), even in the group who received it after a longer/unclear duration of symptoms. Remdesivir recommended for all moderate disease (rather than only if <7d since onset) • Monoclonal antibodies: specifying that Sotrivimab should be used for omicron, and Casrivimab/imdevimab for delta - ID still needs to be involved in all cases. • For receipt of Monoclonal antibodies, have defined the group "predicted to have sub-optimal response to vaccination" as: immunocompromised state with a list of conditions (including hypogammaglobulinemia) • Tocilizumab: global shortage – need to save on vials. Now recommending to switch to a fixed dose (400mg if <75kg; 600mg if 75-99kg; 800mg if > 100kg (rather than 8mg/kg); also suggesting Sarilumab single dose (another IL-6 inhibitor) as an alternative if we run out of tocilizumab. • Cytokine storm criteria removed: this was initially to guide use of Tocilizumab but proven too complex and was not used in any of the studies that showed a benefit with IL-6 inhibitors. Suggesting to focus on ruling out bacterial infection and only using CRP cut-off in cases that are already severe (by resp criteria) • baricitinib an option (but very limited stock) if no IL-6 inhibitors unavailable • Anticoagulation: LMWH dosage recommendations for obesity, pregnancy and eGFR 20-30; for eGFR <20 caution advised; UFH remains nursing intensive and presents Infection control issues – unclear risk/benefit in that population.
V8	Oct 13, 2021	• "Suggested admission criteria": removed the criterion stating “predicted to progress to severe disease if managed as an outpatient” since now offering Monoclonal antibodies (either through ID Day-Hospital or in-patient • Management of mild disease now divided into 2 categories: low risk of progression to severe vs high risk of progression to severe. If high risk, AND presenting within <7d of symptoms --> candidates for Monoclonals (with ID approval); • Management of Moderate disease: MAb to be considered in those within <7d of symptoms and not vaccinated or reason to believe suboptimal response to vaccination • Footnotes related to MAb product.
V7	Feb 9, 2021	• We now recommend to therapeutically anticoagulate mild-moderate cases (rather than prophylactic anticoagulation) – this is based on recent data from 3 international trials, which showed a marked benefit (reduced severity of illness) with therapeutic anticoagulation. No benefit and possible harm noted in severe cases. Though the studies are not published, the guideline working group reached consensus after reviewing data provided by the PIs of the studies. The list of contra-indications to therapeutic anticoagulation is deliberately conservative ie. more cautious than when treating confirmed DVT/PE. • Some clarification around Tocilizumab use (and dosage provided)
V6	Jan 5, 2021	• Admission criteria: among the non-respiratory criteria, replaced our previous “Hematopoietic transplant recipients (HSCT) with high Immunodeficiency Scoring Index ISI*, *or* HIV with CD4 < 200” with a more generic one stating: “Concern for high risk of complications/severe disease if managed in outpatient - based on comorbidities* and living situation”, and added a box listing the comorbidities known to be associated with severe disease (in accordance with CDC and PHAC guidelines). • Empiric Antibiotics: • NO empiric antibiotics for moderate disease. There is now sufficient evidence that rates of superinfection are very low in COVID-19, and there has been significant overprescribing of antibiotic.

		• For patients with severe disease (high flow or mechanical ventilation), empiric antibiotics acceptable: suggest to cover community pathogens with ceftriaxone if hospitalized < 5-days, and broaden coverage with pip-tazo if hospitalized > 5-days • no need for azithro or doxy given data showing no benefit of coverage for atypicals in COVID-19 • New criteria for prediction of COVID-cytokine storm added under "additional considerations": contrary to other criteria/risk calculators (H-Score, MAS score etc), these correlate well with clinical consensus of severe hyperimmune response; based on a recent publication (https://ard.bmj.com/content/80/1/88).
V5	Sept 30, 2020	• Provided criteria for use of Remdesivir outside of clinical trials (only for moderate disease AND < 10 days of symptoms – need ID approval; close monitoring of renal and hepatic functions) • Clarified classification as mild (O_2 sat > 92% on RA), moderate (need supplemental O_2 for O_2Sat > 92%) and severe disease (need high-flow or mechanical ventilation to maintain O_2 sat > 92%) • Removed need for H-score for Tocilizumab use; added comment on very uncertain benefit and high risk of adverse events
V4	Jun 19, 2020	• Dexamethasone added for moderate-severe disease (moderate defined as needing supplemental oxygen; severe defined as needing mechanical ventilation) • Recommendation to NOT start antibiotics UNLESS strong suspicion of bacterial superinfection, or unless critically ill • Documentation of HScore required for Tocilizumab use • Added clinical trial contact info for outpatients and for prophylactic vs therapeutic LMWH in COVID-19 • Removed warning to avoid NSAIDs
V3	Apr 10, 2020	• Clinical trials for COVID initiated (trial coordinator x 32537) • Strong recommendation to D/C all antibiotics if no bacterial growth after 48 hours, and no clinical deterioration; • HScore (for sHLH) added to guide potential use of Tocilizumab (need HScore > 169 and refractory ARDS and ID/ICU approval) • No evidence for *therapeutic* anticoagulation; prophylactic LMWH as per admission guidelines • Removal of empiric oseltamivir for inpatients
V2	Mar 27, 2020	• Change in case definition • Removal of HCQ as standard of care for hospitalized patients *Rationale: early clinical experience at MUHC shows inpatients at MUHC are at high risk of arrhythmias but telemetry/code blue protocol logistically difficult on COVID wards; weak clinical evidence of efficacy of HCQ; upcoming RCT for COVID (info was N/A for earlier version) → risks now outweigh potential benefits.* • Doxycycline OR azithromycin (instead of azithro) for patients with CXR infiltrate • Tocilizumab *may* be considered for severe hyperinflammatory ARDS (HLH/CRS) in conjunction with ID/ICU • Reference to Admission guide for hospitalized patients

V1.2	Mar 20, 2020	• Removal of oseltamivir prescription for *non-hospitalized* patients • Addition of comment that systemic steroids not indicated for COVID-19 • Addition of comment that insufficient data to recommend adding or stopping ACE-inhibitors/ARBs
V1.1	Mar 19, 2020	• Change in case definition (now any ILI regardless of travel or contact) • Changed recommendations re. quarantine: refer to IPC and Sante Publique
V1.0	March 18, 2020	Original version