Clinical Infectious Diseases

IDSA FEATURES

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Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients With COVID-19 (September 2022)

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There are many pharmacologic therapies that are being used or considered for treatment of coronavirus disease 2019 (COVID-19), with rapidly changing efficacy and safety evidence from trials. The objective was to develop evidence-based, rapid, living guidelines intended to support patients, clinicians, and other healthcare professionals in their decisions about treatment and management of patients with COVID-19. In March 2020, the Infectious Diseases Society of America (IDSA) formed a multidisciplinary guideline panel of infectious disease clinicians, pharmacists, and methodologists with varied areas of expertise to regularly review the evidence and make recommendations about the treatment and management of persons with COVID-19. The process used a living guideline approach and followed a rapid recommendation development checklist. The panel prioritized questions and outcomes. A systematic review of the peer-reviewed and grey literature was conducted at regular intervals. The Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach was used to assess the certainty of evidence and make recommendations. Based on the most recent search conducted on 31 May 2022, the IDSA guideline panel has made 32 recommendations for the treatment and management of the following groups/populations: pre- and postexposure prophylaxis, ambulatory with mild-to-moderate disease, and hospitalized with mild-to-moderate, severe but not critical, and critical disease. As these are living guidelines, the most recent recommendations can be found online at: https://idsociety.org/COVID19guidelines. At the inception of its work, the panel has expressed the overarching goal that patients be recruited into ongoing trials. Since then, many trials were conducted that provided much-needed evidence for COVID-19 therapies. There still remain many unanswered questions as the pandemic evolved, which we hope future trials can answer.

Keywords. COVID-19; SARS-Cov-2; corona virus; antivirals; 2019-nCoV.

EXECUTIVE SUMMARY

Coronavirus disease 2019 (COVID-19) is a pandemic with a rapidly increasing incidence of infections and deaths. Many pharmacologic therapies are being used or considered for treatment. Given the rapidity of emerging literature, the Infectious Diseases Society of America (IDSA) identified the need to develop living, frequently updated, evidence-based guidelines to support patients, clinicians, and other healthcare professionals in their decisions about the treatment and management of patients with COVID-19. (Please refer to the IDSA website for the latest version of the guidelines: https://idsociety.org/COVID19guidelines.)

Summarized below are the recommendations with comments related to the clinical practice guideline for the treatment and management of COVID-19. A detailed description of background, methods, evidence summary, and rationale that support each recommendation, and research needs can be found online in the full text. In brief, per Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology, recommendations are labeled as "strong" or "conditional." The word

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"recommend" indicates strong recommendations and "suggest" indicates conditional recommendations. In situations where promising interventions were judged to have insufficient evidence of benefit to support their use and with potential appreciable harms or costs, the expert panel recommended their use in the context of a clinical trial. These recommendations acknowledge the current knowledge gap and aim at avoiding premature favorable recommendations for potentially ineffective or harmful interventions.

Hydroxychloroquine/Chloroquine + Azithromycin

- **Recommendation 1:** Among patients with COVID-19, the IDSA guideline panel recommends against hydroxychloroquine. (strong recommendation, moderate certainty of evidence)
  - **Remark:** Chloroquine is considered to be class equivalent to hydroxychloroquine.
- **Recommendation 2:** Among hospitalized patients with COVID-19, the IDSA guideline panel recommends against hydroxychloroquine plus azithromycin. (strong recommendation, low certainty of evidence)
  - **Remark:** Chloroquine is considered to be class equivalent to hydroxychloroquine.

Hydroxychloroquine for Prophylaxis

- **Recommendation 3:** In persons exposed to COVID-19, the IDSA guideline panel recommends against hydroxychloroquine. (strong recommendation, moderate certainty of evidence)

Lopinavir/Ritonavir

- **Recommendation 4:** In persons exposed to COVID-19, the IDSA guideline panel recommends against postexposure prophylaxis with lopinavir/ritonavir. (strong recommendation, moderate certainty of evidence)
- **Recommendation 5:** Among ambulatory patients with mild-to-moderate COVID-19, the IDSA guideline panel recommends against the use of lopinavir/ritonavir. (strong recommendation, moderate certainty of evidence)
- **Recommendation 6:** Among hospitalized patients with COVID-19, the IDSA guideline panel recommends against the use of the combination lopinavir/ritonavir. (strong recommendation, moderate certainty of evidence)

Glucocorticoids

- **Recommendation 7:** Among hospitalized critically ill patients* with COVID-19, the IDSA guideline panel recommends dexamethasone rather than no dexamethasone. (strong recommendation, moderate certainty of evidence)
  - **Remark**: If dexamethasone is unavailable, equivalent total daily doses of alternative glucocorticoids may be used. Dexamethasone 6 mg IV or orally for 10 days (or until discharge) or equivalent glucocorticoid dose may be substituted if dexamethasone is unavailable. Equivalent total daily doses of alternative glucocorticoids to dexamethasone 6 mg daily are methylprednisolone 32 mg and prednisone 40 mg.
- **Recommendation 8:** Among hospitalized patients with severe**, but noncritical, COVID-19, the IDSA guideline panel suggests dexamethasone rather than no dexamethasone. (conditional recommendation†, moderate certainty of evidence)
  - **Remark**: Dexamethasone 6 mg IV or PO for 10 days (or until discharge) or equivalent glucocorticoid dose may be substituted if dexamethasone is unavailable. Equivalent total daily doses of alternative glucocorticoids to dexamethasone 6 mg daily are methylprednisolone 32 mg and prednisone 40 mg.
- **Recommendation 9:** Among hospitalized patients with mild-to-moderate*** COVID-19 without hypoxemia requiring supplemental oxygen, the IDSA guideline panel suggests against the use of glucocorticoids. (conditional recommendation††, low certainty of evidence)

Severity definitions:

**Critical illness is defined as patients on mechanical ventilation and extracorporeal membrane oxygenation (ECMO). Critical illness includes end-organ dysfunction as is seen in sepsis/septic shock. In COVID-19, the most commonly reported form of end-organ dysfunction is acute respiratory distress syndrome (ARDS).*

***Severe illness is defined as patients with $SpO_2 \leq 94\%$ on room air, including patients on supplemental oxygen.*

****Mild-to-moderate illness is defined as patient with $SpO_2 > 94\%$ not requiring supplemental oxygen.*

†The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.

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Inhaled Corticosteroids

- **Recommendation 10:** Among ambulatory patients with mild-to-moderate COVID-19, the IDSA guideline panel

suggests against inhaled corticosteroids outside of the context of a clinical trial. (conditional recommendation††, moderate certainty of evidence)

††The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.

Interleukin-6 Inhibitors

- **Recommendation 11:** Among hospitalized adults with progressive severe* or critical** COVID-19 who have elevated markers of systemic inflammation, the IDSA guideline panel suggests tocilizumab in addition to standard of care (ie, steroids) rather than standard of care alone. (conditional recommendation†, low certainty of evidence)
  - **Remarks:**
    - Patients, particularly those who respond to steroids alone, who put a high value on avoiding possible adverse events of tocilizumab and a low value on the uncertain mortality reduction, would reasonably decline tocilizumab.
    - In the largest trial on the treatment of tocilizumab, the criterion for systemic inflammation was defined as C-reactive protein (CRP) ≥75 mg/L.
- **Recommendation 12:** When tocilizumab is not available, for patients who would otherwise qualify for tocilizumab, the IDSA guideline panel suggests sarilumab in addition to standard of care (ie, steroids) rather than standard of care alone. (conditional recommendation†, very low certainty of evidence)
  - **Remark:** Patients, particularly those who respond to steroids alone, who put a high value on avoiding possible adverse events of sarilumab and a low value on the uncertain mortality reduction, would reasonably decline sarilumab.

Severity definitions:

**Severe illness is defined as patients with SpO_2 ≤94% on room air, including patients on supplemental oxygen.*

***Critical illness is defined as patients on mechanical ventilation and ECMO. Critical illness includes end-organ dysfunction as is seen in sepsis/septic shock. In COVID-19, the most commonly reported form of end-organ dysfunction is ARDS.*

†The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.

Convalescent Plasma

- **Recommendation 13**: Among patients hospitalized with COVID-19, the IDSA guideline panel recommends against COVID-19 convalescent plasma. (strong recommendation, moderate certainty of evidence)
- **Recommendation 14:** Among ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease who have no other treatment options*, the IDSA guideline panel suggests Food and Drug Administration (FDA)–qualified high-titer COVID-19 convalescent plasma within 8 days of symptom onset rather than no high-titer COVID-19 convalescent plasma. (conditional recommendation†, low certainty of evidence)
  - **Remarks:**
    - In the United States, FDA Emergency Use Authorization (EUA) only authorizes use in patients with immunosuppressive disease or receiving immunosuppressive treatment.
    - Patients, particularly those who are not immunocompromised, who place a low value on the uncertain benefits (reduction in the need for mechanical ventilation, hospitalization, and death) and a high value on avoiding possible adverse events associated with convalescent plasma, would reasonably decline convalescent plasma.

Severity definitions:

**Other options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, symptom duration, renal function, drug interactions) as well as product availability should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.*

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Remdesivir

- **Recommendation 15:** Among patients (ambulatory or hospitalized) with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel suggests remdesivir initiated within 7 days of symptom onset rather than no remdesivir. (conditional recommendation†, low certainty of evidence)
  - **Remarks:**
    - Dosing for remdesivir in mild-to-moderate COVID-19 is 200 mg on day 1 followed by 100 mg on days 2 and 3. Pediatric dosing is

5 mg/kg on day 1 and 2.5 mg/kg on subsequent days.
    - Options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, molnupiravir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, patient age, symptom duration, renal function, drug interactions), product availability, and institutional capacity and infrastructure should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.
- **Recommendation 16:** In patients on supplemental oxygen but not on mechanical ventilation or ECMO, the IDSA panel suggests treatment with 5 days of remdesivir rather than 10 days of remdesivir. (conditional recommendation†, low certainty of evidence)
- **Recommendation 17a:** In hospitalized patients with severe* COVID-19, the IDSA panel suggests remdesivir over no antiviral treatment. (conditional recommendation†, moderate certainty of evidence)
- **Recommendation 17b:** In patients with COVID-19 on invasive ventilation and/or ECMO, the IDSA panel suggests against the routine initiation of remdesivir. (conditional recommendation††, very low certainty of evidence)

Severity definitions:

**Severe illness is defined as patients with SpO_2 ≤94% on room air.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

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Famotidine

- **Recommendation 18:** Among ambulatory patients with mild-to-moderate COVID-19, the IDSA panel suggests against famotidine for the treatment of COVID-19. (conditional recommendation††, low certainty of evidence).
- **Recommendation 19:** Among hospitalized patients with severe* COVID-19, the IDSA panel suggests against famotidine for the treatment of COVID-19. (conditional recommendation††, low certainty of evidence)

Severity definitions:

**Severe illness is defined as patients with SpO_2 ≤94% on room air, including patients on supplemental oxygen.*

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Neutralizing Antibodies for Pre- and Postexposure Prophylaxis

- **Recommendation 20:** In moderately or severely immunocompromised individuals at increased risk for inadequate immune response to COVID-19 vaccine or for persons for whom COVID-19 vaccine is not recommended due to a documented serious adverse reaction to the vaccine, the IDSA guideline panel suggests pre-exposure prophylaxis with tixagevimab/cilgavimab rather than no tixagevimab/cilgavimab, when predominant regional variants* are susceptible** to the agent. (conditional recommendation†, low certainty of evidence)
    - **Remarks:**
        - Dosing for tixagevimab/cilgavimab is 300 mg of tixagevimab and 300 mg of cilgavimab administered as 2 separate consecutive intramuscular injections once.
- **Recommendation 21:** In persons exposed to COVID-19 who are at high risk of progression to severe COVID-19, the IDSA guideline panel suggests postexposure casirivimab/imdevimab only when predominant regional variants* are susceptible** to the agent. (conditional recommendation†, low certainty of evidence)

**For current information on circulating severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) variants in the United States, please visit the Centers for Disease Control and Prevension (CDC) website https://covid.cdc.gov/covid-data-tracker/#variant-proportions.*

***For in vitro susceptibility information for SARS-CoV-2 variants, please visit the Stanford University's Coronavirus Antiviral & Resistance Database https://covdb.stanford.edu/susceptibility-data/table-mab-susc/.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Neutralizing Antibodies for Treatment

- **Recommendation 22:** Among ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel suggests treatment with anti–SARS-CoV-2 monoclonal antibodies with activity** against the predominant regional variants* within 7 days of symptom onset rather than no anti–SARS-CoV-2 monoclonal antibodies.

(conditional recommendation†, moderate certainty of evidence)

- **Remarks:**
  - The evolving nature of variants may necessitate recommendations based on clinical data accrued using agents that are no longer effective against the predominant circulating variants, combined with in vitro data for newer agents.
  - Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital for reasons other than COVID-19 may also receive treatment with anti–SARS-CoV-2 monoclonal antibodies with activity against the predominant regional variant.
  - Although bebtelovimab has shown in vitro activity against Omicron subvariant BA.2, in contrast with previous monoclonal antibodies, clinical safety and efficacy data are sparse with no comparative data in high-risk patients, limiting use to patients who are not candidates for alternative treatments. Patients who place a higher value on greater certainty of benefit may reasonably decline bebtelovimab.

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

**For current information on circulating SARS-CoV-2 variants in the United States, please visit the CDC website.*

***For in vitro susceptibility information for SARS-CoV-2 variants, please visit Stanford University's Coronavirus Antiviral & Resistance Database.*

Janus Kinase Inhibitors

- **Recommendation 23:** Among hospitalized adults with severe* COVID-19, the IDSA panel suggests baricitinib with corticosteroids rather than no baricitinib. (conditional recommendation†, moderate certainty of evidence)
  - **Remarks:**
    - Baricitinib 4 mg/day (or appropriate renal dosing) up to 14 days or until discharge from hospital.
    - Baricitinib appears to demonstrate the most benefit in those with severe COVID-19 on high-flow oxygen/noninvasive ventilation at baseline.
    - Limited additional data suggest a mortality reduction even among patients requiring mechanical ventilation.
- **Recommendation 24:** Among hospitalized patients with severe* COVID-19 who cannot receive a corticosteroid (which is standard of care) because of a contraindication, the IDSA guideline panel suggests use of baricitinib with remdesivir rather than remdesivir alone. (conditional recommendation†, low certainty of evidence)
  - **Remark:** Baricitinib 4 mg daily dose for 14 days or until hospital discharge. The benefits of baricitinib plus remdesivir for persons on mechanical ventilation are uncertain.
- **Recommendation 25:** Among hospitalized adults with severe** COVID-19 but not on noninvasive or invasive mechanical ventilation, the IDSA panel suggests tofacitinib rather than no tofacitinib. (conditional recommendation†, low certainty of evidence)
  - **Remarks:**
    - Tofacitinib appears to demonstrate the most benefit in those with severe COVID-19 on supplemental or high-flow oxygen.
    - Patients treated with tofacitinib should be on at least prophylactic dose anticoagulant.
    - Patients who receive tofacitinib should not receive tocilizumab or other interleukin (IL)-6 inhibitor for treatment of COVID-19.
    - The Study of Tofacitinib in Hospitalized Patients with Covid-19 Pneumonia (STOP-COVID) Trial did not include immunocompromised patients.

Severity definitions:

**Severe illness is defined as patients with $SpO_2 \leq 94\%$ on room air, including patients on supplemental oxygen, oxygen through a high-flow device, or noninvasive ventilation.*

***Severe illness is defined as patients with $SpO_2 \leq 94\%$ on room air, including patients on supplemental oxygen or oxygen through a high-flow device.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Ivermectin

- **Recommendation 26:** In hospitalized patients with COVID-19, the IDSA panel suggests against ivermectin. (conditional recommendation††, very low certainty of evidence)
- **Recommendation 27:** In ambulatory persons with COVID-19, the IDSA panel recommends against ivermectin. (strong recommendation, moderate certainty of evidence)

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists,*

and most informed people would choose the suggested course of action, while a substantial number would not.

Fluvoxamine

- **Recommendation 28:** Among ambulatory patients with COVID-19, the IDSA guideline panel recommends fluvoxamine only in the context of a clinical trial. (knowledge gap)

Nirmatrelvir/Ritonavir

- **Recommendation 29:** In ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel suggests nirmatrelvir/ritonavir initiated within 5 days of symptom onset rather than no nirmatrelvir/ritonavir. (conditional recommendation†, low certainty of evidence)
  - **Remarks:**
    - Patients' medications need to be screened for serious drug interactions (ie, medication reconciliation). Patients on ritonavir- or cobicistat-containing human immunodeficiency virus (HIV) or hepatitis C virus regimens should continue their treatment as indicated.
    - Dosing based on renal function:
      - Estimated glomerular filtration rate (eGFR) >60 mL/minute: 300 mg nirmatrelvir/100 ritonavir every 12 hours for 5 days.
      - eGFR ≤60 mL/minute and ≥30 mL/minute: 150 mg nirmatrelvir/100 mg ritonavir every 12 hours for 5 days.
      - eGFR <30 mL/minute: not recommended.
    - Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital for reasons other than COVID-19 may also receive nirmatrelvir/ritonavir.
  - Options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, molnupiravir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, symptom duration, renal function, drug interactions) as well as product availability should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.

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Molnupiravir

- **Recommendation 30:** In ambulatory patients (≥18 years) with mild-to-moderate COVID-19 at high risk for progression to severe disease who have no other treatment options*, the IDSA guideline panel suggests molnupiravir initiated within 5 days of symptom onset rather than no molnupiravir. (conditional recommendation†, low certainty of evidence)
  - **Remarks:**
    - Patients who put a higher value on the putative mutagenesis, adverse events, or reproductive concerns and a lower value on the uncertain benefits would reasonably decline molnupiravir.
    - Molnupiravir 800 mg for 5 days.
    - Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital for reasons other than COVID-19 may also receive molnupiravir.
    - Molnupiravir is not authorized under the FDA EUA for use in patients <18 years because it may affect bone and cartilage growth.
    - Molnupiravir is not recommended under the FDA EUA for use during pregnancy.
    - Molnupiravir is not authorized under the FDA EUA for pre-exposure or postexposure prevention of COVID-19 or for initiation of treatment in patients hospitalized due to COVID-19 because benefit of treatment has not been observed in individuals when treatment is started after hospitalization due to COVID-19.

Severity definitions:

**Other options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, symptom duration, renal function, drug interactions) as well as product availability should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Colchicine

- **Recommendation 31:** In hospitalized patients with COVID-19, the IDSA panel recommends against

colchicine for treatment of COVID-19. (strong recommendation, moderate certainty of evidence)

- **Recommendation 32:** In ambulatory persons with COVID-19, the IDSA panel suggests against colchicine for treatment of COVID-19. (conditional recommendation††, moderate certainty of evidence)

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At the inception of its work, the panel expressed the overarching goal that patients be recruited into ongoing trials, which would provide much-needed evidence on the efficacy and safety of various therapies for COVID-19. Since then, many trials were conducted which provided much-needed evidence for COVID-19 therapies. There still remain many unanswered questions as the pandemic evolved, which we hope future trials can answer. The panel has determined that when explicit trade-offs between highly uncertain benefits and known putative harms of these therapeutic agents were considered, a net positive benefit was not reached and could possibly be negative (risk of excess harm). The panel acknowledges that enrolling patients in randomized controlled trials (RCTs) might not be feasible for many frontline providers due to limited access and infrastructure. Should lack of access to clinical trials exist, we encourage setting up local or collaborative registries to systematically evaluate the efficacy and safety of drugs to contribute to the knowledge base. Each clinician can play a role in advancing our understanding of this disease through a local registry or other data collection efforts.

BACKGROUND

The first cases of coronavirus disease 2019 (COVID-19) were reported from Wuhan, China, in early December 2019 [1], now known to be caused by a novel beta-coronavirus, named as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Within a span of months, COVID-19 became a pandemic due to its transmissibility, spreading across continents with the number of cases and deaths rising daily [2]. The emergence of new variants as the pandemic evolved has added more challenges to the prevention and treatment of COVID-19. Although most infected individuals exhibit a mild illness (≥80%), 14% have serious and 5% have critical illness. Approximately 10% will require hospital admission due to COVID-19 pneumonia, of whom approximately 10% will require intensive care, including invasive ventilation due to acute respiratory distress syndrome (ARDS) [3]. While mortality appears to be more common in older individuals and those with comorbidities, such as chronic lung disease, cardiovascular disease, hypertension, and diabetes, young people with no comorbidities also appear to be at risk for critical illness including multiorgan failure and death.

There has been an expanding number of studies rapidly published online and in academic journals; however, some of these may be of limited quality and are pre-published without sufficient peer review. Critical appraisal of the existing studies is needed to determine if the existing evidence is sufficient to support currently proposed management strategies.

Given the rapid global spread of SARS-CoV-2 and the difficulty for the overburdened frontline providers and policymakers to stay up to date on emerging literature, the Infectious Diseases Society of America (IDSA) has recognized the necessity of developing a rapid guideline for the treatment of COVID-19. The guideline panel is using a methodologically rigorous process for evaluating the best available evidence and providing treatment recommendations. These guidelines will be frequently updated as substantive literature becomes available and are accessible on an easy to navigate web and device interface at http://www.idsociety.org/COVID19guidelines.

There continue to be several ongoing trials evaluating therapeutic agents for the treatment of COVID-19. As data become available from these trials and if there is a preponderance of evidence to suggest the use of a therapeutic agent, even in the context of clinical trials, is no longer warranted it will be removed from future updates of the guideline (and the removal will be noted in the updated guidelines). If there is emerging evidence on the efficacy or safety of a therapeutic agent not mentioned in the current version of the guideline it will be included in future updates of the guideline.

These recommendations are intended to inform patients, clinicians, and other health professionals by providing the latest available evidence.

METHODS

This guideline was developed in 2 stages. First, an initial rapid systematic review was conducted to inform the first iteration of the guideline. Second, while maintaining a current evidence base, the guideline scope expanded to update existing recommendations and include additional therapies, as needed, using a living guideline approach. Given the need for continued urgent responses to this major public health crisis, the methodological approach follows the Guidelines International Network/McMaster checklist for the development of rapid recommendations [4].

Panel Composition

The initial guideline panel assembled in March 2020 was composed of 9 members including infectious diseases (ID) specialists as well as experts in public health as well as other frontline clinicians, specializing in pharmacology, pediatrics, medical microbiology, preventive care, critical care, hepatology,

nephrology, and gastroenterology. Organizational representatives were included from the Society for Healthcare Epidemiology of America (SHEA) and the Pediatric Infectious Diseases Society (PIDS). In May 2020, an additional panel member was included as a representative from the Society of Infectious Diseases Pharmacists (SIDP). One member rotated off the panel in March of 2022 and was replaced by a pediatric ID specialist and an adult ID specialist with expertise in antiviral drug-resistance testing. The Evidence Foundation provided technical support and guideline methodologists for the development of this guideline.

Disclosure and Management of Potential Conflicts of Interest

All members of the expert panel complied with the conflicts of interest process for reviewing and managing conflicts of interest, which requires disclosure of any financial, intellectual, or other interest that might be construed as constituting an actual, potential, or apparent conflict, regardless of relevancy to the guideline topic. The assessment of disclosed relationships for possible conflicts of interest is based on the relative weight of the financial relationship (ie, monetary amount) and the relevance of the relationship (ie, the degree to which an association might reasonably be interpreted by an independent observer as related to the topic or recommendation of consideration). The conflicts of interest (COI) review group has ensured that the majority of the panel and chair are without potential relevant (related to the topic) conflicts for the duration of their term on the panel. The chair and all members of the technical team have been determined to be unconflicted.

Question Generation

Clinical questions included in this guideline were developed into a PICO (Population, Intervention, Comparison, Outcomes) format [5] and prioritized according to available evidence that met the minimum acceptable criteria (ie, the body of evidence reported on at least a case-series design; case reports were excluded). Panel members prioritized patient-important outcomes such as mortality, hospitalization, development of severe disease (eg, need for noninvasive or invasive ventilation) and clinical improvement (such as disease-oriented outcomes inferred by radiological findings or virologic cure), and severe adverse events leading to treatment discontinuation. Serious adverse events are death; life-threatening reactions; and those that require hospitalization, result in disability or permanent damage, or require an intervention to prevent permanent impairment [6]. Additional drug-specific harms were evaluated when clinically relevant, including possible drug–drug reactions, if applicable.

Critical and important outcomes for decision making varied across populations/groups. For example, among hospitalized patients (at any disease severity), critical outcomes included mortality, need for invasive mechanical ventilation, duration of hospitalization, failure of clinical improvement, adverse events, and serious adverse events. Among ambulatory populations with COVID-19 infection, the outcome of hospitalization replaced duration of hospitalization. Among persons receiving pre-exposure prophylaxis (PrEP) or postexposure prophylaxis (PEP), outcomes included measures of symptomatic COVID-19 infection.

Search Strategy

The National Institute for Health and Care Excellence (NICE) highly sensitive search was reviewed by the methodologist in consultation with the technical team information specialist and was determined to have high sensitivity [7]. An additional term, COVID, was added to the search strategy used, in addition to the treatment terms identified in the PICO questions (Supplementary Table 1). Per the living guideline approach, monthly searches are conducted in Ovid Medline and Embase, building on the literature searched from 2019. This document reflects literature searched through 31 May 2022. Horizon scans have been performed regularly during the evidence assessment and recommendation process to locate additional grey literature, including manuscript preprints. Reference lists and literature suggested by panelists were reviewed for inclusion. No restrictions were placed on language or study type.

Screening and Study Selection

Two reviewers independently screened titles and abstracts, as well as eligible full-text studies. Eligible studies reported on persons with confirmed COVID-19 and compared the active intervention against no active intervention (eg, standard of care or other treatment equally distributed across both the intervention and comparison arm). For questions on PrEP or PEP, persons at baseline could not have reported COVID-19 infection. When acceptable randomized controlled trials (RCTs) of effectiveness were found, no additional nonrandomized studies or noncomparative evidence (ie, single-arm case series) were sought. Evidence from single-arm studies reporting on noncomparative rates of outcomes of interest were included if a historical control event rate could be estimated from the literature. Conflicts were resolved through discussion or with a third reviewer.

Data Collection and Analysis

Reviewers extracted relevant information into a standardized data extraction form, including the following: study characteristics, study design, participant characteristics, details of the intervention and comparison, outcomes reported, and funding source. We extracted the number of events and total sample to calculate a risk ratio and corresponding 95% confidence interval (CI) for dichotomous outcomes. For continuous outcomes, either a mean and standard deviation or a standard

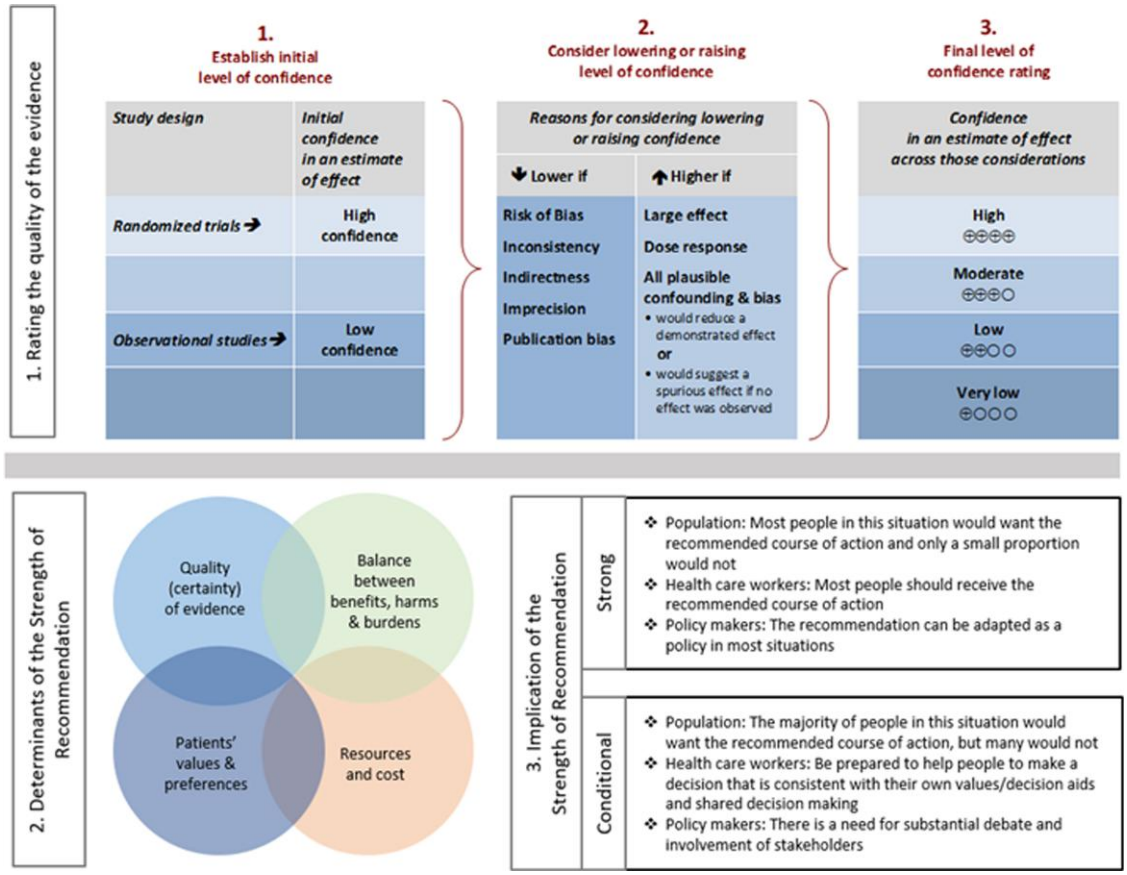

Figure 1. Approach and implications to rating the quality of evidence and strength of recommendations using GRADE methodology (unrestricted use of figure granted by the US GRADE Network). Abbreviation: GRADE, Grading of Recommendations Assessment, Development, and Evaluation.

mean difference were calculated. Where applicable, data were pooled using a random-effects model (fixed-effects model for ≤2 trials or pooling of rates) and presented in a forest plot using RevMan (https://training.cochrane.org/online-learning/core-software/revman) [8].

Risk of Bias and Certainty of Evidence

Risk of bias was assessed using the Cochrane Risk of Bias Tool for RCTs and the Risk of Bias Instrument for Non-randomized Studies–of Interventions (ROBINS-I) [9, 10]. The certainty of evidence (CoE) was assessed using the GRADE approach [11]. Within GRADE, the body of evidence across each outcome is assessed for domains that may reduce or increase one's certainty in the evidence. Factors that may reduce one's certainty include risk of bias (study limitations), inconsistency (unexplained heterogeneity across study findings), indirectness (applicability or generalizability to the research question), imprecision (the confidence in the estimate of an effect to support a particular decision), or publication bias (selective publication of studies). One's certainty in the evidence may be strengthened if the following considerations are present: large or very large magnitude of effect, evidence of a dose–response gradient, or opposing residual confounding. The GRADE summary of findings tables were developed using the GRADEpro Guideline Development Tool [12].

The outcomes informing decision making for specific treatments may change to reflect the availability of higher-quality direct evidence for critical clinical outcomes. For example, at the time of the first guideline, clinical improvement outcomes (eg, need for mechanical ventilation) were not reported; only the results of radiographic findings. However, with the recent publication of RCTs and nonrandomized studies reporting on direct measures of clinical improvement, results of radiographic studies were deemed to be less critical for decision making.

Evidence to Recommendations

The panel considered core elements of the GRADE evidence in the decision process, including CoE and balance between desirable and undesirable effects. Additional domains were acknowledged, where applicable (feasibility, resource use,

acceptability). For all recommendations, the expert panelists reached consensus. Voting rules were agreed on prior to the panel meetings for situations when consensus could not be reached. If the panel is deciding because there is a strong or a conditional recommendation (based on moderate or high-certainty evidence) in the same direction, 80% of the panel must vote for a strong recommendation. In situations of uncertainty between the desirable and undesirable consequences (typically based on low or very low CoE), when the panel is deciding between a conditional recommendation or no recommendation, 50% of the panel must vote for the same option with less than 20% voting for the alternative option.

As per GRADE methodology, recommendations are labeled as "strong" or "conditional." The words "we recommend" indicate strong recommendations and "we suggest" indicate conditional recommendations. Figure 1 provides the suggested interpretation of strong and weak recommendations for patients, clinicians, and healthcare policymakers. For recommendations where the comparators are not formally stated, the comparison of interest is implicitly referred to as "not using the intervention." These recommendations acknowledge the current "knowledge gap" and aim at avoiding premature favorable recommendations for their use and to avoid encouraging the rapid diffusion of potentially ineffective or harmful interventions. Detailed suggestions about the specific research questions that should be addressed are found in Supplementary Table 2.

Review Process

This guideline has been rapidly reviewed and approved by the IDSA Board of Directors Executive Committee external to the guideline development panel. SHEA, PIDS, and SIDP have reviewed and provided endorsement of its contents.

Updating Process and Terminology

As detailed in the Methods section, the living guideline is supported by monthly screening of the literature. The impetus for updating a current recommendation is based on the identification of peer-reviewed or publicly available grey literature reporting data for at least 1 critical outcome that would likely have an impact on the recommendations. This could reflect new information on a critical outcome that previously had no included evidence, changes to the absolute effect of a critical outcome (magnitude or precision), or changes to the certainty of a critical outcome. In such situations, the entire expert panel is reconvened to review the evidence and put forward a proposal for a change in the recommendation.

Changes to these guidelines fall into 1 of 3 categories: update, amendment, or retirement. An update involves a search for new studies, and if any new studies are found, they will be critically appraised and the pertinent section will be removed and replaced with the updated section. An amendment involves a change or correction to the document without any search for new studies and their appraisal. It will also involve changes made to clarify or explain a section based on "living" feedback from the readers. Due to lack of continued relevancy of a treatment option, the guideline panel may choose to retire a section. While the retired section will not appear in the manuscript, all sections with accompanying dates will be available on the IDSA website.

RESULTS

A systematic review and horizon scan of the literature identified 68 968 references, of which 147 informed the evidence base for these recommendations (Supplementary Figure 1). Characteristics of the included studies can be found in the Supplementary Materials.

Hydroxychloroquine/Chloroquine; Hydroxychloroquine/Chloroquine Plus Azithromycin

Section last reviewed and updated 23 December 2020
Last literature search conducted 14 December 2020

Recommendation 1: Among hospitalized patients with COVID-19, the IDSA guideline panel recommends against hydroxychloroquine. (strong recommendation, moderate certainty of evidence)

- **Remark:** Chloroquine is considered to be class equivalent to hydroxychloroquine.

Recommendation 2: Among hospitalized patients with COVID-19, the IDSA guideline panel recommends against hydroxychloroquine plus azithromycin. (strong recommendation, low certainty of evidence)

- **Remark:** Chloroquine is considered to be class equivalent to hydroxychloroquine.

Why Are Hydroxychloroquine and Hydroxychloroquine Plus Azithromycin Considered for Treatment?

Hydroxychloroquine (HCQ) and chloroquine are 4-aminoquinoline drugs developed in the mid-20th century for the treatment of malaria [13]. Hydroxychloroquine differs from chloroquine only in the addition of a hydroxyl group and is associated with a lower incidence of adverse effects with chronic use [13]. Both drugs have been used in the treatment of autoimmune diseases because of their immunomodulatory effects on several cytokines, including interleukin (IL)-1 and IL-6 [13]. There is some evidence that these drugs also have antiviral properties against many different viruses, including the coronaviruses [14, 15]. They have demonstrated in vitro activity against SARS-CoV-2, which ranges considerably between studies but is generally within the range of predicted achievable tissue concentrations [14, 16–18]. The in vitro activity, the

Table 1. GRADE Evidence Profile, Recommendation 1—Question: Hydroxychloroquine Compared to No Hydroxychloroquine for Hospitalized Patients With COVID-19 (*Last Reviewed and Updated 23 December 2020*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Hydroxychloroquine	No Hydroxychloroquine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (RCTs) (follow-up: range 22 days to 49 days)												
5 [28, 29, 32–34]	randomized trials	not serious[a]	not serious	not serious[b]	serious[c]	none	561/2976 (18.9%)	908/4532 (20.0%)	**RR 1.08** (.99 to 1.19)	**16 more per 1000** (from 2 fewer to 38 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Clinical status (assessed with 7-point scale; higher signifies worsening severity)												
1 [28]	randomized trials	serious[d]	not serious	not serious	serious[e]	none	159	173	…	median **1.21 higher** (0.69 higher to 2.11 higher)	⊕⊕◯◯ LOW	CRITICAL
Progression to invasive mechanical ventilation												
2 [29, 32]	randomized trials	serious[f]	not serious	not serious	serious[c]	none	193/2162 (8.9%)	281/3447 (8.2%)	**RR 1.10** (.92 to 1.31)	**8 more per 1000** (from 7 fewer to 25 more)	⊕⊕◯◯ LOW	CRITICAL
Arrhythmias												
1 [39]	observational studies	very serious[g]	not serious	not serious	very serious[e,h]	none	44/271 (16.2%)	23/221 (10.4%)	**RR 1.56** (.97 to 2.50)	**58 more per 1000** (from 3 fewer to 156 more)	⊕◯◯◯ VERY LOW	CRITICAL
Adverse events, any												
4 [28, 30, 31, 35, 38]	randomized trials	serious[i]	not serious	not serious	serious[e]	none	94/315 (29.8%)[j]	18/176 (10.2%)[k]	**RR 2.36** (1.49 to 3.75)	**139 more per 1000** (from 50 more to 281 more)	⊕⊕◯◯ LOW	IMPORTANT
Severe adverse events (assessed with untoward medical event leading to death, a life-threatening experience, prolongation of hospitalization, or persistent or significant disability or incapacity)												
1 [33]	randomized trials	not serious	not serious	not serious	very serious[e]	none	14/242 (5.8%)	11/237 (4.6%)	**OR 1.26** (.56 to 2.84)[l]	**11 more per 1000** (from 20 fewer to 75 more)	⊕⊕◯◯ LOW	CRITICAL
QT prolongation (RCTs)												
1 [28]	randomized trials	not serious	not serious	not serious	very serious[h]	none	13/89 (14.6%)	1/58 (1.7%)	**RR 8.47** (1.14 to 63.03)	**129 more per 1000** (from 2 more to 1000 more)	⊕⊕◯◯ LOW	IMPORTANT

Table 1. Continued

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Hydroxychloroquine	No Hydroxychloroquine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
QT prolongation (NRS)												
2 [38, 39]	observational studies	very serious[g,m]	not serious	not serious	serious[h]	none	46/355 (13.0%)	13/311 (4.2%)	**RR 2.89** (1.62 to 5.16)	**79 more per 1000** (from 26 more to 174 more)	⊕◯◯◯ VERY LOW	IMPORTANT

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: AST, aspartate transaminase; CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; OR, odds ratio; NRS, non randomized studies; RCT, randomized controlled trial; RR, risk ratio; URI, upper respiratory infection.

[a]Co-interventions were provided to patients in both studies but balanced across arms.

[b]Cavalcanti et al [28] excludes persons receiving supplemental oxygen at a rate of >4 L per minute.

[c]The 95% CI cannot exclude the potential for no benefit or harm.

[d]Cavalcanti et al [28] was an open-label trial.

[e]The 95% CI includes the potential for both benefit and harm. Few events suggest the potential for fragility in the estimate.

[f]Few events suggest the potential for fragility in the estimate.

[g]Concerns with unmeasured and residual confounding. Multiple co-interventions received across arms.

[h]Few events reported do not meet the optimal information size and suggest fragility in the estimate.

[i]Did not report on blinding (including outcome adjudication committee), sequence generation, or allocation concealment; Chen J et al [30]: all patients received nebulized alpha-interferon, 80% versus 67.7% of subjects received umifenovir (https://en.wikipedia.org/wiki/Umifenovir) in the hydroxychloroquine versus placebo arm, respectively. Two subjects in the control arm received lopinavir/ritonavir.

[j]Chen J et al [30]: 4 adverse events include diarrhea, fatigue, and transient AST elevation. Chen Z et al [31]: 1 rash, 1 headache. Tang et al [35]: 21 adverse events include disease progression (1%), URI (1%), diarrhea (10%), vomiting (3%).

[k]Three adverse events reported in 2 patients include AST elevation, creatinine elevation, and anemia.

[l]Adusted OR: age, sex, baseline COVID Outcome Scale category, baseline Sequential Organ Failure Assessment score, and duration of acute respiratory infection symptoms prior to randomization.

[m]Mahevas et al [38] does not report on adverse events in the comparator arm.

Table 2. GRADE Evidence Profile, Recommendation 2—Question: Hydroxychloroquine and Azithromycin Compared to No Hydroxychloroquine/Azithromycin for Hospitalized Patients With COVID-19 (*Last Updated 20 August 2020; Last Reviewed 23 December 2020*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Hydroxychloroquine	No Hydroxychloroquine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (RCTs) (follow-up: range 22 days to 49 days)												
1 [28]	randomized trials	not serious[a]	not serious	not serious[b]	very serious[c,d]	none	5/172 (2.9%)	6/173 (3.5%)	**HR 0.64** (.18 to 2.21)	**12 fewer per 1000** (from 28 fewer to 40 more)	⊕⊕◯◯ LOW	CRITICAL
Mortality (NRS)												
3 [37, 39, 41]	observational studies	very serious[e]	not serious	not serious	serious[d]	none	Three nonrandomized studies failed to identify an association between persons treated with HCQ + AZ and mortality: Ip reported an adjusted HR of 0.98 (95% CI: .75, 1.28); Magagnoli et al [37] reported an adjusted HR in a subset after propensity score adjustment of 0.89 (95% CI: .45, 1.77); Rosenberg et al [39] reported an adjusted HR of 1.35 (95% CI: .79, 2.40) (Ip, Magagnoli et al [37], Rosenberg et al [39]).				⊕◯◯◯ VERY LOW	CRITICAL
Clinical status (assessed with 7-point scale, higher values represent worse clinical outcomes)												
1 [28]	randomized trials	serious[f]	not serious	not serious[b]	serious[d,g]	none	172	173	…	MD **0.99 higher** (0.57 higher to 1.73 higher)	⊕⊕◯◯ LOW	CRITICAL
Virologic failure (follow-up: range 5 days to 6 days; assessed with PCR test)												
2 [19, 43, 44]	observational studies	very serious[h]	serious[i]	serious[j]	serious[c]	none	29/71 (40.8%)[k]	12/12 (100.0%)[l]	not estimable	…	⊕◯◯◯ VERY LOW	IMPORTANT
QT prolongation (RCTs)												
1 [28]	randomized trials	not serious	not serious	serious[m,n]	serious[c]	none	17/116 (14.7%)	1/58 (1.7%)	**RR 8.50** (1.16 to 62.31)	**129 more per 1000** (from 3 more to 1000 more)	⊕⊕◯◯ LOW	IMPORTANT
QT prolongation (NRS)												
2 [43, 45]	observational studies	very serious[h]	not serious	serious[n]	serious[c]	none	10/95 (10.5%)[n]	…	…	…	⊕◯◯◯ VERY LOW	IMPORTANT

Table 2. Continued

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Hydroxychloroquine	No Hydroxychloroquine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Serious adverse events[p]												
1 [28]	randomized trials	serious[f]	not serious	not serious[o]	serious[c,d]	none	5/239 (2.1%)	0/50 (0.0%)	**RR 2.34** (.13 to 41.61)	**0 fewer per 1000** (from 0 fewer to 0 fewer)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: AST, aspartate transaminase; AZ, azithromycin; CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HCQ, hydrochloroquine; HR, hazard ratio; MD, mean difference; NRS, non randomized study; RCT, randomized controlled trial; RR, risk ratio.

[a]Co-interventions were provided to patients but balanced across arms. Cavalcanti et al [28] was open label; however, likely did not influence the outcome of mortality.

[b]Cavalcanti et al [28] excludes persons receiving supplemental oxygen at a rate of >4 L per minute.

[c]A very small number of events. Optimal information size not met.

[d]The 95% CI includes the potential for both benefit and harm.

[e]Concerns with unmeasured and residual confounding. Multiple co-interventions received across arms.

[f]Cavalcanti et al [28] was an open-label trial.

[g]Optimal information size not met.

[h]No contemporaneous control groups; no adjustment for baseline severity, resulting in high risk for residual confounding.

[i]Two case series from France showed divergent results.

[j]Surrogate marker for mortality or resolution of COVID-19.

[k]Gautret et al [19] reported 21/61 patients as positive at day 6 (estimate from supplied graph); Molina et al [43] reported 8/10 patients positive at day 5 or 6. Pooled rates of virologic failure using fixed-effects inverse variance method resulted in a 43% failure rate (95% CI: 32% to 54%).

[l]Gautret et al [44] reported on a historical viral clearance rate in symptomatic patients from a separate hospital. Criteria for selection of patients remain unclear, as presumably a sizable number of untreated patients could have been available with data on viral clearance.

[m]Indirect measure of arrhythmia-specific mortality.

[n]Azithromycin and hydroxychloroquine can independently cause QT prolongation. Used together there can be an additive effect. Caution should be exercised with other agents known to prolong the QT interval.

[o]Molina et al [43]: 1/11 leading to treatment discontinuation; Chorin et al [45]: 9/84 with significant QTc prolongation of >500 ms.

[p]Cavalcanti et al [28] serious adverse events included pulmonary embolism, QTc prolongation, myocardial infarction, abdominal-wall hemorrhage.

extensive use for other conditions, and widespread availability of generic versions of the drug made it an attractive option for the treatment of COVID-19. Interest in combinations of HCQ with azithromycin (AZ) began when investigators in a small, uncontrolled study of HCQ use for COVID-19 noticed a higher frequency of patients achieving virologic response in the 6 subjects who received AZ to prevent bacterial infection [19]. Azithromycin, widely utilized as an antibacterial agent, has also been shown to have in vitro antiviral activity against a variety of ribonucleic acid (RNA) viruses [20–22]. While the exact mechanism of antiviral activity is unknown, possibilities include inhibiting endocytosis and limiting viral replication [23] and the induction of interferon [22, 24]. Macrolides have also been shown to have anti-inflammatory activity [25, 26].

Summary of the Evidence

Our search identified 8 RCTs and 7 comparative cohort studies of hospitalized patients with confirmed COVID-19 treated with HCQ with reported mortality, clinical progression or clinical improvement, and adverse events outcomes [27–41] (Table 1) (Supplementary Table 3a).

In addition, we identified 2 RCTs, 4 comparative cohort studies, 1 case-control study, and 3 single-arm studies reporting adjusted analyses of hospitalized patients with confirmed COVID-19 treated with HCQ plus AZ with reported mortality, failure of virologic clearance (assessed with polymerase chain reaction [PCR] test), clinical improvement, and adverse events (ie, significant QT prolongation leading to treatment discontinuation) [19, 27, 28, 37, 39, 41–45] (Table 2) (Supplementary Table 3b).

Benefits

Hydroxychloroquine. Five RCTs showed a trend toward mortality among patients with COVID-19 treated with HCQ compared with those who were not (relative risk [RR]: 1.08; 95% CI: .99, 1.19; moderate certainty in the evidence) (Table 1) [28, 29, 33].

Hydroxychloroquine + Azithromycin. One RCT could not exclude the risk of in-hospital mortality among patients treated with HCQ + AZ compared with those not receiving HCQ or HCQ + AZ (hazard ratio [HR]: .64; 95% CI: .18, 2.21; low CoE) [28]. Three nonrandomized studies failed to identify an association between treatment with HCQ + AZ and mortality: Ip et al [41] reported an adjusted HR of 0.98 (95% CI: .75, 1.28); Magagnoli et al [37] reported an adjusted HR in a subset after propensity score adjustment of .89 (95% CI: .45, 1.77); Rosenberg et al [39] reported an adjusted HR of 1.35 (95% CI: .79, 2.40). As stated in the HCQ section, 1 nonrandomized study reported a reduction in mortality among patients receiving HCQ + AZ (HR: .29; 95% CI: .22, .40); however, it failed to adjust for the critical confounder of disease severity and imbalances in steroid use [27]. As described in the HCQ section, similar methodologic concerns exist among patients allocated to HCQ + AZ in the Arshad et al [27] study, leading to several sources of bias in interpreting their favorable results.

Harms

Hydroxychloroquine. One RCT reported that persons treated with HCQ experienced a longer time until hospital discharge (median: 16 days compared with 13 days) and a lower probability of being discharged alive within the 28-day study period (rate ratio: .92; 95% CI: .85, .99) [29]. In addition, persons treated with HCQ who were not on mechanical ventilation at baseline were more likely to be placed on mechanical ventilation during follow-up (rate ratio: 1.10; 95% CI: .92, 1.31; low CoE) [29, 32]. Across the body of evidence from 4 RCTs, treatment with HCQ may increase the risk of experiencing adverse events (RR: 2.36; 95% CI: 1.49, 3.75; low CoE) and severe adverse events (adjusted odds ratio [OR]: 1.26; 95% CI: .56, 2.84; low CoE) [28, 30, 31, 35]. One RCT and 2 nonrandomized studies suggest increased risk of QT prolongation among patients treated with HCQ compared with those not receiving HCQ (RR: 8.47; 95% CI: 1.14, 63.03 [low CoE]; and RR: 2.89; 95% CI: 1.62, 5.16 [very low CoE], respectively) [28, 38, 39]. In addition, Rosenberg et al [39] reported that 16% of patients in the HCQ arm experienced arrhythmias compared with 10% in the non-HCQ arm (RR: 1.56; 95% CI: .97, 2.50; very low CoE).

Gastrointestinal side effects occurred in 7% of patients in a prospective cohort study in 224 COVID-19–uninfected patients with systemic lupus erythematosus (SLE) who received either chloroquine or HCQ for routine care [46].

While the 4-aminoquinolines, chloroquine and HCQ, have not been demonstrated to cause hemolysis in people with glucose-6-phosphate dehydrogenase (G6PD) deficiency [47, 48], case reports of hemolysis have emerged when these agents have been used for the treatment of COVID-19 [49–51]. It is possible that infection with SARS-CoV-2 may trigger hemolysis in G6PD-deficient individuals in the absence of a 4-aminoquinolone. Caution should be exercised in administering these agents to G6PD-deficient individuals with COVID-19, particularly if used for extended durations.

Renal clearance accounts for 15–25% of total clearance of HCQ; however, dose adjustments are not recommended with kidney dysfunction. Chloroquine and HCQ are metabolized by cytochrome P450 isoenzymes 2C8, 2D6, and 3A4 [52]. Therefore, inhibitors and inducers of these enzymes may result in altered pharmacokinetics of these agents.

Hydroxychloroquine + Azithromycin. One RCT suggests increased risk of QT prolongation among patients treated with HCQ + AZ compared with those not receiving HCQ (RR: 8.50; 95% CI: 1.16, 62.31; low CoE) [28]. Two studies described significant

QT prolongation in 10 of 95 patients treated with HCQ + AZ, illustrating the high risk for clinically relevant arrhythmias with this treatment [43, 45]. In addition, several case reports of QT prolongation related to HCQ have also been published [53–56]. A case-control study of persons with COVID-19 treated with HCQ + AZ compared with healthy, untreated controls reported higher values of minimum (415 vs 376 ms), mean (453 vs 407 ms), and maximum QTc-interval (533 vs 452 ms) among COVID-19 cases (n = 22) compared with controls (n = 34) [42].

Additional case reports have cited the risk of a prolonged QT prolongation, torsades de pointes, and ventricular tachycardia in patients without COVID-19 receiving AZ alone. In a large-cohort study, patients taking a 5-day course of AZ had an increased risk of sudden cardiac death, with an HR of 2.71 (95% CI: 1.58–4.64) vs .85 (95% CI: .45–1.60), compared with patients receiving either no antibiotic or amoxicillin, respectively [57]. Given the cumulative effect on cardiac conduction seen with HCQ and AZ, if this combination was used, baseline and follow-up electrocardiogram (ECG) monitoring would be indicated, as well as careful surveillance for other concomitant medications known to prolong the QT interval.

Azithromycin has a low risk for cytochrome P450 interactions [58]; however, additional pharmacologic adverse events including gastrointestinal effects and QT prolongation need to be carefully considered, particularly in the outpatient setting where frequent ECG monitoring is not feasible.

Providers are encouraged to visit resources such as https://www.COVID19-druginteractions.org/ to aid in the evaluation and management of drug interactions with current and emerging investigational agents for COVID-19.

Other Considerations

The panel agreed that the overall CoE against treatment with HCQ was moderate due to concerns with imprecision around the risk for a trend towards harms from increased mortality. When considering the addition of AZ, the overall CoE was low; however, the panel recognized even greater concern with the toxicity. In addition, based on the moderate certainty of increased QT prolongation, the panel determined that this demonstrated certain harm with uncertain benefit; therefore, the panel made a strong recommendation against HCQ + AZ.

Conclusions and Research Needs for This Recommendation

The guideline panel recommends against the use of either HCQ alone or in combination with AZ in the hospital setting as higher certainty benefits (eg, mortality reduction) are now highly unlikely even if additional high-quality RCTs would become available.

This recommendation does not address the use of AZ for secondary bacterial pneumonia in patients with COVID-19 (Supplementary Table 2).

Hydroxychloroquine as Postexposure Prophylaxis

Section last reviewed and updated 23 September 2021
Last literature search conducted 21 September 2021

Recommendation 3: In persons exposed to COVID-19, the IDSA guideline panel recommends against hydroxychloroquine. (strong recommendation, moderate certainty of evidence)

Why Is Hydroxychloroquine Considered for Postexposure Prophylaxis?

There is some evidence that HCQ has antiviral properties against many different viruses, including the coronaviruses [14, 15]. It has demonstrated in vitro activity against SARS-CoV-2, which ranges considerably between studies, but is generally within the range of predicted achievable tissue concentrations [14, 16–18]. The in vitro activity, the extensive use for other conditions, and widespread availability of generic versions of the drug made it an attractive option for treatment and prophylaxis of COVID-19; however, at this point, HCQ has not been identified as effective for treatment of COVID-19.

Summary of the Evidence

Our search identified 3 RCTs that reported on HCQ PEP of contacts of those diagnosed with SARS-CoV-2 infection [59–61]. Patients in these studies were randomized to HCQ or placebo or no additional treatment. All 3 studies evaluated for the presence of SARS-CoV-2 at day 14, 2 of the studies required a positive test for SARS-CoV-2, while 1 study allowed symptoms suggestive of COVID-19 to meet the outcome when a test was not completed. Additional outcomes included hospitalization, mortality, and serious adverse events.

Benefits

Outpatients. Hydroxychloroquine appears to have a trivial or no effect on the development of symptomatic SARS-CoV-2 infection at day 14 compared with no HCQ (RR: .95; 95% CI: .77, 1.16; moderate CoE). In addition, HCQ showed a trivial or no effect on the rate of hospitalization (RR: 1.00; 95% CI: .47, 2.12; 3 fewer to 7 more hospitalizations in 1000; low CoE) or mortality (RR: .45; 95% CI: .16, 1.28; 5 fewer to 2 more deaths in 1000; low CoE).

Harms

There was no difference in serious adverse events in the HCQ rather than no HCQ for PEP (RR: .91; 95% CI: .47, 1.76; low CoE). Additional side effects and harms of HCQ (eg, QT prolongation, arrhythmias, gastrointestinal effects) have been summarized in recommendation 1 (HCQ for treatment of hospitalized persons with COVID-19).

Other Considerations

The panel made an explicit decision that:

(a) The primary outcome driving the decision for any PEP is the ability to prevent infection
(b) When the evidence demonstrates a very low likelihood of effective PEP, other outcomes become secondary
(c) When healthy persons are considered for preventive medications (such as would occur in postexposure settings), a higher threshold for benefits is required and (even putative) harms become more important

The panel agreed that the overall CoE against prophylaxis treatment with HCQ was moderate (failure to prevent infection) due to concerns with imprecision. The panel balanced the lack of clear benefit with the increased risk of harms from the body of evidence reported in the treatment section, in addition to the side effects reported in the trials to make a strong recommendation.

Conclusions and Research Needs for This Recommendation

The guideline panel recommended against the use of HCQ as postexposure prophylactic treatment for persons exposed to COVID-19 (Table 3).

Lopinavir/Ritonavir

Section last reviewed and updated 16 February 2022
Last literature search conducted 31 January 2022

Recommendation 4: In persons exposed to COVID-19, the IDSA guideline panel recommends against postexposure prophylaxis with lopinavir/ritonavir. (strong recommendation, moderate certainty of evidence)

Recommendation 5: Among ambulatory patients with mild-to-moderate COVID-19, the IDSA guideline panel recommends against the use of lopinavir/ritonavir. (strong recommendation, moderate certainty of evidence)

Recommendation 6: Among hospitalized patients with COVID-19, the IDSA guideline panel recommends against the use of the combination lopinavir/ritonavir. (strong recommendation, moderate certainty of evidence)

Why Is Lopinavir Plus Ritonavir Considered for Treatment?

Lopinavir/ritonavir is a protease inhibitor that was US Food and Drug Administration (FDA)–approved for the treatment of human immunodeficiency virus (HIV) in September 2000. Ritonavir is added to the combination as a pharmacokinetic enhancer due to its strong inhibition of cytochrome P450 3A4, a metabolic pathway for lopinavir metabolism. Lopinavir/ritonavir demonstrated in vitro inhibition of SARS-CoV-1 and Middle Eastern respiratory syndrome coronavirus (MERS-CoV) replication [62–64]. A trial of lopinavir/ritonavir and ribavirin versus historical controls in patients with SARS-CoV-1 showed a reduced rate of ARDS and mortality in those receiving lopinavir/ritonavir. This study had limitations, including a control group from early in the outbreak when management strategies likely differed significantly [65]. During the MERS outbreak, case reports cited efficacy of lopinavir/ritonavir with interferon in the management of patients with MERS [66, 67]. During the early phase of COVID-19, a triple combination of interferon-B1b, lopinavir/ritonavir, and ribavirin shortened the duration of viral shedding and hospital stay in patients with mild-to-moderate COVID-19 in an open-label, randomized, phase II trial [68].

Summary of the Evidence

One RCT reported on PEP with combination lopinavir/ritonavir or placebo for ambulatory persons exposed to COVID-19 [69]. During the follow-up period of 21 days, the investigators reported on symptomatic SARS-CoV-2 infection (COVID) either independent of baseline PCR/serology or among those who had a negative PCR test/serology at baseline.

One RCT reported on treatment with combination lopinavir/ritonavir or placebo for ambulatory patients with mild-to-moderate COVID-19 [70]. During the follow-up of 90 days, COVID-19–related hospitalizations as well as mortality were recorded (Tables 4 and 5).

Three RCTs reported on treatment with combination lopinavir/ritonavir or placebo for hospitalized patients with COVID-19 [32, 71, 72] (Table 6). The trials reported on the following outcomes: mortality, failure of clinical improvement (measured using a 7-point scale or hospital discharge), need for mechanical ventilation, and adverse events leading to treatment discontinuation.

Benefits

Among persons exposed to COVID-19, prophylactic treatment with lopinavir/ritonavir failed to show or exclude a beneficial effect on symptomatic SARS-CoV-2 infection, either independent of baseline PCR/serology or among those with a negative PCR and serology at baseline (HR: .60; 95% CI: .29, 1.26 [moderate CoE]; and HR: .59; 95% CI: .17, 2.02 [moderate CoE], respectively).

Among ambulatory patients with mild-to-moderate COVID-19, lopinavir/ritonavir failed to show or excluded a beneficial effect on COVID-19–related hospitalizations or deaths (HR: 1.16; 95% CI: .53, 2.56 [moderate CoE]; and HR: 1.86; 95% CI: .17, 20.4 [low CoE], respectively).

Among hospitalized patients with COVID-19, treatment with lopinavir/ritonavir failed to show or exclude a beneficial effect on mortality or need for invasive mechanical ventilation (RR: 1.00; 95% CI: .89, 1.13 [moderate CoE]; and RR: 1.12; 95% CI: .93, 1.34 [low CoE]). Similarly, lopinavir/ritonavir may

Table 3. GRADE Evidence Profile, Recommendation 3—Question: Hydroxychloroquine Compared to No Hydroxychloroquine for Postexposure Prophylaxis of COVID-19 (*Last Reviewed and Updated 23 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Hydroxychloroquine	No Hydroxychloroquine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Symptomatic SARS-CoV-2 infection (follow-up: 14 days)[a]												
3 [59–61]	randomized trials	not serious	not serious	not serious	serious[b]	none	166/1883 (8.8%)	177/1941 (9.1%)	**RR 0.95** (.77 to 1.16)	**5 fewer per 1000** (from 21 fewer to 15 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalization (follow-up: 14 days)												
3 [59–61]	randomized trials	not serious	not serious	not serious	very serious[b]	none	13/2018 (0.6%)	14/2129 (0.7%)	**RR 1.00** (.47 to 2.12)	**0 fewer per 1000** (from 3 fewer to 7 more)	⊕⊕◯◯ LOW	CRITICAL
Mortality (follow-up: 14 days)												
3 [59–61]	randomized trials	not serious	not serious	not serious	very serious[b]	none	5/2018 (0.2%)	12/2129 (0.6%)	**RR 0.45** (.16 to 1.28)	**3 fewer per 1000** (from 5 fewer to 2 more)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: 14 days)												
3 [59–61]	randomized trials	not serious	not serious	not serious	very serious[b]	none	16/2018 (0.8%)	19/2129 (0.9%)	**RR 0.91** (.47 to 1.76)	**1 fewer per 1000** (from 5 fewer to 7 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Boulware et al [60] included both laboratory-confirmed COVID-19 as well as probable COVID-19; 11/49 patients receiving hydroxychloroquine were laboratory confirmed and 9/58 receiving placebo were laboratory confirmed.

[b]The 95% CI includes both the potential of benefit and the risk of harm.

Table 4. GRADE Evidence Profile, Recommendation 4—Question: Prophylactic Lopinavir/Ritonavir Compared to No Prophylactic Lopinavir/Ritonavir for Persons Exposed to COVID-19 (*Last Reviewed and Updated 16 February 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Prophylactic Lopinavir/Ritonavir	No Prophylactic Lopinavir/Ritonavir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Symptomatic SARS-CoV-2 infection (COVID-19) regardless of baseline PCR/serology (follow-up: 21 days)												
1 [69]	randomized trials	not serious	not serious	not serious	serious[a]	none	35/209 (16.7%)	13/109 (11.9%)	**HR 0.60** (.29 to 1.26)[b]	**46 fewer per 1000** (from 83 fewer to 29 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Symptomatic SARS-CoV-2 infection (COVID-19), negative PCR and serology at baseline (follow-up: 21 days)												
1 [69]	randomized trials	not serious	not serious	not serious	serious[a]	none	8/159 (5.0%)	7/90 (7.8%)	**HR 0.59** (.17 to 2.02)	**31 fewer per 1000** (from 64 fewer to 73 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Adverse events (follow-up: 29 days)												
1 [69]	randomized trials	serious[c]	not serious	not serious	not serious	none	175/207 (84.5%)[d]	33/107 (30.8%)	**RR 2.74** (2.05 to 3.66)	**537 more per 1000** (from 324 more to 820 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; PCR, polymerase chain reaction; RR, risk ratio; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

[a]Few events, unable to exclude benefits as well as harms.

[b]This prespecified primary endpoint adjusted analysis is a mixed-model analysis adjusted for baseline imbalance.

[c]Participants not blinded to lopinavir/ritonavir.

[d]Two serious adverse events occurred and both judged by the author as unrelated to lopinavir/ritonavir.

Table 5. GRADE Evidence Profile, Recommendation 5—Question: Lopinavir/Ritonavir Compared to No Lopinavir/Ritonavir for Ambulatory Patients With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 16 February 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Lopinavir/ Ritonavir	No Lopinavir/ Ritonavir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 90 days)												
1 [70]	randomized trials	not serious	not serious	not serious	very serious[a]	none	2/244 (0.8%)	1/227 (0.4%)	**RR 1.86** (.17 to 20.40)	**4 more per 1000** (from 4 fewer to 85 more)	⊕⊕◯◯ LOW	CRITICAL
COVID-19–related hospitalizations (follow-up: 90 days)												
1 [70]	randomized trials	not serious	not serious	not serious	serious[a]	none	14/244 (5.7%)	11/227 (4.8%)	**HR 1.16** (.53 to 2.56)	**8 more per 1000** (from 22 fewer to 71 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events (follow-up: 90 days)												
1 [70]	randomized trials	not serious	not serious	not serious	serious[a]	none	20/232 (8.6%)	12/220 (5.5%)	**RR 1.58** (0.79 to 3.16)	**32 more per 1000** (from 11 fewer to 118 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; RR, risk ratio.

[a]Sparse data, few events, unable to excluded harms as well as benefits.

Table 6. GRADE Evidence Profile, Recommendation 6—Question: Lopinavir/Ritonavir Compared to No Lopinavir/Ritonavir for Hospitalized Patients With Severe COVID-19 (*Last Reviewed and Updated 22 November 2020*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Lopinavir/ Ritonavir	Placebo	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
3 [32, 71, 72]	randomized trials	not serious[a]	not serious	not serious	serious[b]	none	538/3111 (17.3%)[c]	938/4896 (19.2%)	**RR 1.00** (.89 to 1.13)	**0 fewer per 1000** (from 21 fewer to 25 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Invasive mechanical ventilation (follow-up: 28 days)												
2 [71, 72]	randomized trials	serious[a,d]	not serious	not serious	serious[b]	none	166/1655 (10.0%)	297/3380 (8.8%)	**RR 1.12** (.93 to 1.34)	**11 more per 1000** (from 6 fewer to 30 more)	⊕⊕◯◯ LOW	CRITICAL
Adverse events leading to treatment discontinuation												
1 [71]	randomized trials	serious[a]	not serious	not serious	very serious[e]	none	Nearly 14% of lopinavir–ritonavir recipients were unable to complete the full 14-day course of administration. This was due primarily to gastrointestinal adverse events, including anorexia, nausea, abdominal discomfort, or diarrhea, as well as 2 serious adverse events, both acute gastritis. Two recipients had self-limited skin eruptions. Such side effects, including the risks of hepatic injury, pancreatitis, more severe cutaneous eruptions, and QT prolongation, and the potential for multiple drug interactions due to CYP3A inhibition, are well documented with this drug combination. The side-effect profile observed in the current trial arouses concern about the use of higher or more prolonged lopinavir–ritonavir dose regimens in efforts to improve outcomes.				⊕◯◯◯ VERY LOW	IMPORTANT
Failure of clinical improvement at 14 days (follow-up: 14 days)												
1 [71]	randomized trials	serious[a]	not serious	not serious	very serious[f]	none	54/99 (54.5%)	70/100 (70.0%)	**RR 0.78** (0.62 to 0.97)	**154 fewer per 1000** (from 266 fewer to 21 fewer)	⊕◯◯◯ VERY LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Unblinded studies which can affect outcomes that require judgment, such as how investigators judge clinical improvement or decide to stop the treatment in patients with side effects.

[b]95% CI may not include a meaningful difference.

[c]Modified intention-to-treat data from Cao et al [71] used for this outcome; some deaths were excluded when drug was not given.

[d]One patient randomized to the lopinavir-ritonavir arm in Cao et al [71] was mechanically ventilated at baseline.

[e]Small number of events making estimates highly uncertain.

[f]The upper boundary of the 95% CI crosses the threshold of meaningful improvement as the worst-case estimate is a 3% RRR, relative risk reduction.

reduce failure of clinical improvement at 14 days, but it is uncertain (RR: .78; 95% CI: .63, .97; very low CoE).

Harms

Prophylactic treatment of persons exposed to SARS-CoV-2 with lopinavir/ritonavir compared with placebo increases the risk of adverse events (RR: 2.74; 95% CI: 2.05, 3.66; moderate CoE). The most common adverse events were nausea/vomiting, diarrhea, abdominal pain, lack of appetite, itching, and bloating.

Treatment of COVID-19 in ambulatory persons with lopinavir/ritonavir rather than placebo may increase the risk of serious adverse events (RR: 1.58; 95% CI: .79, 3.16; moderate CoE). The Randomized Evaluation of COVID-19 Therapy (RECOVERY) trial reported 1 in 1588 serious adverse events due to treatment with lopinavir/ritonavir [72]; however, nearly 14% of lopinavir/ritonavir recipients in Cao et al [71] were unable to complete the full 14-day course of administration. This was due primarily to gastrointestinal adverse events, including anorexia, nausea, abdominal discomfort, or diarrhea, as well as 2 serious adverse events, both acute gastritis. Two recipients had self-limited skin eruptions. Such side effects, including the risks of hepatic injury, pancreatitis, more severe cutaneous eruptions, and QT prolongation, and the potential for multiple drug interactions due to CYP3A inhibition, are well documented with this drug combination. The side-effect profile observed in these trials raises concerns about the use of higher or more prolonged lopinavir/ritonavir dose regimens in efforts to improve outcomes.

Other Considerations

The panel determined the CoE to be moderate due to concerns with imprecision for most critical outcomes across indications. The guideline panel made a strong recommendation against treatment with the combination of lopinavir/ritonavir for PEP, and ambulatory as well as hospitalized patients with COVID-19.

Conclusions and Research Needs for This Recommendation

The guideline panel recommends against treatment with lopinavir/ritonavir across patient groups at risk for or with COVID-19.

Glucocorticoids

Section last reviewed and updated 25 September 2020
Last literature search conducted 4 September 2020

Recommendation 7: **Among hospitalized critically ill patients* with COVID-19, the IDSA guideline panel recommends dexamethasone rather than no dexamethasone. (strong recommendation, moderate certainty of evidence)**

- **Remark**: If dexamethasone is unavailable, equivalent total daily doses of alternative glucocorticoids may be used. Dexamethasone 6 mg IV or PO for 10 days (or until discharge) or equivalent glucocorticoid dose may be substituted if dexamethasone is unavailable. Equivalent total daily doses of alternative glucocorticoids to dexamethasone 6 mg daily are methylprednisolone 32 mg and prednisone 40 mg.

Recommendation 8: Among hospitalized patients with severe, but noncritical, COVID-19, the IDSA guideline panel suggests dexamethasone rather than no dexamethasone. (conditional recommendation†, moderate certainty of evidence)**

- **Remark**: Dexamethasone 6 mg IV or PO for 10 days (or until discharge) or equivalent glucocorticoid dose may be substituted if dexamethasone is unavailable. Equivalent total daily doses of alternative glucocorticoids to dexamethasone 6 mg daily are methylprednisolone 32 mg and prednisone 40 mg.

Recommendation 9: Among hospitalized patients with mild-to-moderate* COVID-19 without hypoxemia requiring supplemental oxygen, the IDSA guideline panel suggests against the use of glucocorticoids. (conditional recommendation††, low certainty of evidence)**

Severity definitions:

**Critical illness is defined as patients on mechanical ventilation and ECMO. Critical illness includes end-organ dysfunction as is seen in sepsis/septic shock. In COVID-19, the most commonly reported form of end-organ dysfunction is ARDS.*

***Severe illness is defined as patients with SpO_2 ≤94% on room air, including patients on supplemental oxygen.*

****Mild-to-moderate illness is defined as patient with SpO_2 >94% not requiring supplemental oxygen.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

The last literature search was conducted on 4 September 2020, and we identified 8 RCTs and 7 comparative nonrandomized studies.

Why Are Corticosteroids Considered for Treatment?

In the early days of the SARS-CoV-2 pandemic, based on experience in both SARS and MERS, recommendations [73] cautioned against the use of systemic corticosteroids due to the

risk of worsening clinical status, delayed viral clearance, and adverse events [74–76]. Given the hyperinflammatory state in COVID-19, immunomodulatory approaches, including steroids, continue to be evaluated to address both ARDS and systemic inflammation. ARDS stemming from dysregulated systemic inflammation may translate into prolonged ventilatory requirements and in-hospital mortality. In nonviral ARDS settings, there is increasing support for the role of steroids in the management of ARDS [77]. A recent multicenter RCT in patients with moderate to severe ARDS demonstrated a reduced number of ventilatory days and reduction in mortality with use of a 10-day regimen of dexamethasone [78].

Summary of the Evidence

Critical Illness. Our search identified 1 systematic review that analyzed 8 RCTs reporting on treatment with glucocorticoids among 1844 critically ill patients with COVID-19 [79]. Three RCTs reported on patients treated with low- and high-dose dexamethasone [78, 80, 81]; 3 RCTs reported on patients treated with low-dose hydrocortisone [82–84]; and 2 RCTs reported on patients treated with high-dose methylprednisolone [79, 85]. The definition of critically ill varied across trials; however, the majority of patients had ARDS.

Severe and Mild-to-Moderate Illness. Our search identified 1 RCT, 1 "partially" randomized trial, 1 prospective cohort, and 5 retrospective cohort studies [80, 86–92]. The RCT provided the best available evidence on treatment with corticosteroids for persons with COVID-19 [80] (Tables 7–9). Corral-Gudino et al [86] reported on a study that randomized patients to receive methylprednisolone or standard of care; however, patients expressing a preference for methylprednisolone were assigned to the same treatment arm. Corral-Gudino et al did not report the disaggregated results from the randomized trial, therefore succumbing to the same potential for bias as reported subsequently for the nonrandomized studies. The nonrandomized studies had significant limitations with controlling for multiple cointerventions and disease severity at baseline [87–92]. All nonrandomized studies had concerns with risk of bias due to lack of adjustment for critical confounders or potential for residual confounding. Timing of receipt, dose, and duration of corticosteroids varied across studies (Table 10).

The RECOVERY trial is a randomized trial among hospitalized patients in the United Kingdom [80]. In that study, 2104 participants were randomized to receive dexamethasone (6 mg daily for up to 10 days) and 4321 were randomized to usual care. The RECOVERY trial reported on the outcomes of mortality and hospital discharge. Participants and study staff were not blinded to the treatment arms.

Benefits

Critical Illness. Among hospitalized, critically ill patients, the odds of mortality at 28 days was 34% less among patients treated with glucocorticoids than among patients not treated with glucocorticoids (OR: .66; 95% CI: .54; 0.82; high CoE). In addition, at 28 days, patients receiving dexamethasone were more likely to be discharged from the hospital (RR: 1.11; 95% CI: 1.04, 1.19; moderate CoE).

Severe Illness. Among hospitalized patients, 28-day mortality was 17% lower in the group that received dexamethasone than in the group that did not receive dexamethasone (RR: .83; 95% CI: .74, .92; moderate CoE). In addition, at 28 days, patients receiving dexamethasone were more likely to be discharged from the hospital (RR: 1.11; 95% CI: 1.04, 1.19; moderate CoE).

Mild-to-Moderate Illness. In a subgroup analysis of patients without hypoxia not receiving supplemental oxygen, there was no evidence for benefit and a trend toward harm with dexamethasone in participants who were not on supplemental oxygen (RR: 1.22; 95% CI: .86, 1.75; low CoE).

Harms

A systematic review of 6 studies did not report a difference in the number of serious adverse events experienced by patients randomized to receive treatment with glucocorticoids or no treatment with glucocorticoids (64/354 among those receiving glucocorticoids vs 80/342 among those not receiving glucocorticoids).

Patients receiving a short course of steroids may experience hyperglycemia, neurological side effects (eg, agitation/confusion), adrenal suppression, and risk of bacterial and fungal infection [87, 93, 94].

Other Considerations

Critical Illness. The panel agreed that the overall CoE for treatment with glucocorticoids for patients with critical COVID-19 was moderate due to concerns with indirectness and imprecision.

Severe Illness. The panel agreed that the overall CoE for treatment with glucocorticoids for patients with severe COVID-19 was moderate due to concerns with indirectness since the evidence was from dexamethasone.

Mild-to-Moderate Illness. The panel agreed that the overall CoE for patients without hypoxemia requiring supplemental oxygen was low due to concerns with risk of bias (post hoc analysis) and imprecision.

The panel agreed that the overall CoE for treatment with glucocorticoids for patients with severe COVID-19 was moderate

Table 7. GRADE Evidence Profile, Recommendation 7—Question: Glucocorticoids Compared to No Glucocorticoids for Critically Ill Patients With COVID-19 (*Last Reviewed and Updated 25 September 2020*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Corticosteroids	No Corticosteroids	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
8 [79]	randomized trials	not serious	not serious	not serious	not serious	none	280/749 (37.4%)	485/1095 (44.3%)	**OR 0.66** (.54 to .82)	**99 fewer per 1000** (from 143 fewer to 48 fewer)	⊕⊕⊕⊕ HIGH	CRITICAL
Hospital discharge (follow-up: 28 days)												
1 [80]	randomized trials	not serious[a]	not serious	serious[b]	not serious	none	1360/2104 (64.6%)	2639/4321 (61.1%)	**RR 1.11** (1.04 to 1.19)	**67 more per 1000** (from 24 more to 116 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Serious adverse events												
6 [79]	randomized trials	not serious	not serious	not serious	serious [c]	none	Six trials reported 64 events among 354 patients randomized to corticosteroids and 80 events among 342 patients randomized to standard care (Stern et al [10]).				⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; OR, odds ratio; RR, risk ratio.

[a]Analysis adjusted for baseline age.

[b]Indirectness due to different healthcare system (allocation of intensive care resources in an unblinded study). Indirectness to other corticosteroids.

[c]The 95% CI includes the potential for both harm as well as benefit. Few events reported do not meet the optimal information size and suggest fragility in the estimate.

Table 8. GRADE Evidence Profile, Recommendation 8—Question: Glucocorticoids Compared to No Glucocorticoids for Hospitalized Patients With Severe But Not Critical COVID-19 (*Last Reviewed and Updated 25 September 2020*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Glucocorticoids	No Glucocorticoids	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
1 [80]	randomized trials	not serious[a]	not serious	serious[b]	not serious	none	454/2104 (21.6%)	1065/4321 (24.6%)	**RR 0.83** (.74 to .92)	**42 fewer per 1000** (from 64 fewer to 20 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Hospital discharge (follow-up: 28 days)												
1 [80]	randomized trials	not serious[a]	not serious	serious[b]	not serious	none	1360/2104 (64.6%)	2639/4321 (61.1%)	**RR 1.11** (1.04 to 1.19)	**67 more per 1000** (from 24 more to 116 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Adverse events												
–	–	–	–	–	–	–	Patients receiving a short course of steroids may experience hyperglycemia, neurological side effects (eg, agitation/confusion), adrenal suppression, and risk of infection (Salton et al [87]; Henzen et al [93]; Siemieniuk et al [94]).				–	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Analysis adjusted for baseline age.

[b]Indirectness due to different healthcare system (allocation of intensive care resources in an unblinded study). Indirectness to other corticosteroids.

Table 9. GRADE Evidence Profile, Recommendation 9—Question: Glucocorticoids Compared to No Glucocorticoids for Hospitalized Patients With COVID-19 Not Receiving Supplemental Oxygen (*Last Reviewed and Updated 25 September 2020*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Glucocorticoids	No Glucocorticoids	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
1 [80]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	85/501 (17.0%)	137/1034 (13.2%)	**RR 1.22** (.93 to 1.61)	**29 more per 1000** (from 9 fewer to 81 more)	⊕⊕◯◯ LOW	CRITICAL
Hospital discharge (follow-up: 28 days)												
1 [80]	randomized trials	serious [a]	not serious	not serious	serious[c]	none	366/501 (73.1%)	791/1034 (76.5%)	**RR 0.99** (.87 to 1.12)	**8 fewer per 1000** (from 99 fewer to 92 more)	⊕⊕◯◯ LOW	IMPORTANT
Adverse events												
–	–	–	–	–	–	–	Patients receiving a short course of steroids may experience hyperglycemia, neurological side effects (eg, agitation/confusion), adrenal suppression, and risk of infection (Salton et al [87]; Henzen et al [93]; Siemieniuk et al [94]).				–	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Risk of bias due to post hoc subgroup effect among persons not receiving supplemental oxygen.

[b]The 95% CI includes the potential for appreciable harm and cannot exclude the potential for benefit. Few events reported do not meet the optimal information size and suggest fragility in the estimate.

[c]The 95% CI cannot exclude the potential for either appreciable harm or benefit.

due to concerns with indirectness since the evidence was from dexamethasone. The panel agreed that the overall CoE for patients without hypoxemia requiring supplemental oxygen was low due to concerns with risk of bias (post hoc analysis) and imprecision.

Conclusions and Research Needs for This Recommendation

The guideline panel recommends dexamethasone for patients with critical COVID-19. The guideline panel suggests dexamethasone for patients with severe COVID-19. If dexamethasone is not available, then alternative glucocorticoids may be used (see details above). The guideline panel suggests against glucocorticoids for patients with COVID-19 without hypoxemia requiring supplemental oxygen.

Additional research is needed to inform the generalizability of treatment with different glucocorticoids for patients with COVID-19 (Supplementary Table 2).

Inhaled Corticosteroids

Section last reviewed and updated 14 March 2022

Last literature search conducted 28 February 2022

Recommendation 10: Among ambulatory patients with mild-to-moderate COVID-19, the IDSA guideline panel suggests against inhaled corticosteroids outside of the context of a clinical trial. (conditional recommendation††, moderate certainty of evidence)

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Are Inhaled Corticosteroids Considered for Treatment?

Systemic corticosteroids have become a mainstay of therapy for the management of systemic inflammation seen in patients with severe COVID-19 infection as a result of the mortality reduction demonstrated in the RECOVERY trial [100]. In addition to their anti-inflammatory properties, some corticosteroids have been shown to inhibit viral replication of coronaviruses, including MERS-CoV. Specifically, ciclesonide has demonstrated the ability to block SARS-CoV-2 viral replication in vitro, whereas fluticasone and dexamethasone did not [101]. Therefore, ciclesonide, and potentially other corticosteroids, may offer both anti-inflammatory and antiviral activity for the management of SARS-CoV-2. The antiviral mechanism may be related to the action of corticosteroids on both angiotensin-converting enzyme 2 (ACE2) and transmembrane protease serine 2 (TMPRSS2), which mediate SARS-CoV-2 viral attachment and entry into host cells. Preliminary data from a clinical cohort of patients taking inhaled corticosteroids suggest a lower expression of ACE2 and TMPRSS2 compared with those not taking inhaled corticosteroids and may suggest decreased susceptibility to SARS-CoV-2 in those taking inhaled corticosteroids [102].

Summary of the Evidence

Five RCTs reported on the use of inhaled corticosteroids budesonide or ciclesonide compared with placebo or no treatment with inhaled corticosteroids for ambulatory or hospitalized patients with mild-to-moderate COVID-19 [95–99]. These trials reported on the outcomes of mortality, COVID-19–related hospitalization, and serious adverse events.

Benefits

Among patients with mild-to-moderate COVID-19, inhaled corticosteroids failed to show or exclude a beneficial effect on mortality or COVID-19–related hospitalization (RR: .61; 95% CI: .22, 1.67; absolute risk reduction: 3 fewer per 1000 [from 7 fewer to 6 more]; and RR: .67; 95% CI: .36, 1.26 [moderate CoE], respectively).

Harms

Serious adverse events may be less frequent among patients with mild-to-moderate disease receiving treatment with inhaled corticosteroids rather than no inhaled corticosteroids; however, this may not be meaningfully different from those not receiving inhaled corticosteroids (RR: .78; 95% CI: .29, 2.09; moderate CoE).

Other Considerations

The panel determined the CoE of treatment of inhaled corticosteroids for patients with mild-to-moderate COVID-19 to be moderate due to concerns with imprecision, as effects failed to show or exclude a beneficial effect for mortality or COVID-19–related hospitalization. The guideline panel made a conditional recommendation against inhaled corticosteroids outside of the context of a clinical trial.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests against inhaled corticosteroids for the treatment of patients with mild-to-moderate COVID-19 unless in the context of a clinical trial. More information is needed about the interaction of inhaled corticosteroids with a 5-day course of ritonavir as part of nirmatrelvir/ritonavir treatment. When potent CYP 3A4 pharmacokinetic boosters like ritonavir or cobicistat are utilized for durations greater than 5 days in patients with HIV or hepatitis C, most inhaled corticosteroids are not recommended for coadministration due to the risk of Cushing's syndrome and adrenal suppression [103]. This may be a consideration when prescribing inhaled steroids if concomitantly used with nirmatrelvir/ritonavir.

Interleukin-6 Inhibitors

Section last reviewed and updated 14 September 2021

Table 10. GRADE Evidence Profile, Recommendation 10—Question: Inhaled Corticosteroids Compared to No Inhaled Corticosteroids for Ambulatory Patients With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 14 March 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Inhaled Corticosteroids	No Inhaled Corticosteroids	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: range 14 days to 30 days)												
4 [95–98]	randomized trials	not serious[a]	not serious	not serious[b]	serious[c]	none	6/1127 (0.5%)	10/1135 (0.9%)	**RR 0.61** (.22 to 1.67)	**3 fewer per 1000** (from 7 fewer to 6 more)	⊕⊕⊕◯ MODERATE	CRITICAL
COVID-19–related hospitalizations (follow-up: range 14 days to 30 days)												
4 [95–97, 99]	randomized trials	serious[a]	not serious	not serious[d]	serious[c]	none	78/1162 (6.7%)	109/1178 (9.3%)	**RR 0.67** (.36 to 1.26)	**31 fewer per 1000** (from 59 fewer to 24 more)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: range 14 days to 30 days)												
3 [95, 98, 99]	randomized trials	not serious[a]	not serious	not serious	serious[c]	none	7/928 (0.8%)	9/928 (1.0%)	**RR 0.78** (.29 to 2.09)	**2 fewer per 1000** (from 7 fewer to 11 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Ramakrishnan et al [99] and Yu et al [95] were open-label trials, which may introduce bias into outcomes subjectively measured, such as COVID-19–related hospitalizations and serious adverse events.

[b]Eight of 35 patients in Song et al [98] received hydroxychloroquine in addition to ciclesonide. All patients in Song et al [98] had mild-to-moderate COVID-19 and were hospitalized.

[c]Sparse data, few events, unable to excluded harms as well as benefits.

[d]In Yu et al [95] et al the following patients were admitted to hospital without need for supplemental oxygen: budesonide, 17/787 (2%); placebo, 21/799 (3%).

Last literature search conducted 31 August 2021

Recommendation 11: Among hospitalized adults with progressive severe* or critical COVID-19 who have elevated markers of systemic inflammation, the IDSA guideline panel suggests tocilizumab in addition to standard of care (ie, steroids) rather than standard of care alone. (conditional recommendation†, low certainty of evidence)**

Remarks:

- Patients, particularly those who respond to steroids alone, who put a high value on avoiding possible adverse events of tocilizumab and a low value on the uncertain mortality reduction, would reasonably decline tocilizumab.
- In the largest trial on the treatment of tocilizumab, the criterion for systemic inflammation was defined as CRP ≥75 mg/L.

Recommendation 12: When tocilizumab is not available for patients who would otherwise qualify for tocilizumab, the IDSA guideline panel suggests sarilumab in addition to standard of care (ie, steroids) rather than standard of care alone. (conditional recommendation†, very low certainty of evidence)

- **Remark:** Patients, particularly those who respond to steroids alone, who put a high value on avoiding possible adverse events of sarilumab and a low value on the uncertain mortality reduction, would reasonably decline sarilumab.

***Severity definitions*:**

**Severe illness is defined as patients with SpO_2 ≤94% on room air, including patients on supplemental oxygen.*

***Critical illness is defined as patients on mechanical ventilation and ECMO. Critical illness includes end-organ dysfunction as is seen in sepsis/septic shock. In COVID-19, the most commonly reported form of end-organ dysfunction is ARDS.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Are Interleukin-6 Receptor Antagonists Considered for Treatment?

Some patients with COVID-19 develop a hyperinflammatory syndrome that is characterized by elevations in proinflammatory cytokines and multiorgan dysfunction also known as the immunopathology of SARS-CoV-2 infection. The significance of these findings is unclear; however, early descriptions found that those with elevated IL-6 levels and evidence of hyperinflammation had increased rates of more severe disease [104, 105]. Tocilizumab, a monoclonal anti–IL-6-receptor blocking antibody, has been proposed as a therapeutic agent to mitigate hyperinflammation associated with COVID-19. Tocilizumab is FDA-approved for various rheumatologic conditions as well as cytokine release syndrome associated with Chimeric antigen receptor (CAR) T-cell therapy.

Sarilumab, another IL-6 receptor antagonist, is currently FDA-approved for rheumatoid arthritis (RA).

Summary of the Evidence

Tocilizumab. Our search identified 8 RCTs (including preprints) that reported on patients with severe COVID-19 randomized to treatment with tocilizumab (8 mg/kg) or placebo/usual care [106–113]. Gordon et al [106], Horby et al [108], Rosas et al [109], and Veiga et al [113] allowed for patients to be on mechanical ventilation at randomization, whereas the other trials included patients with a lower disease severity (eg, allowed supplemental oxygen but excluded those on higher levels of oxygen support) or included patients with severe COVID with an inflammatory phenotype.

One trial, RECOVERY, contributed the majority of the weight in the analysis [108]. RECOVERY trial participants must have demonstrated clinical evidence of progressive COVID-19, which was defined as less than 92% oxygen saturation on room air or receiving oxygen and CRP ≥75 mg/L. Use of steroids was balanced across both the participants receiving tocilizumab and those not receiving tocilizumab. Following recommendations for treatment with glucocorticoids, 82% of participants in both arms received dexamethasone. While RECOVERY did not blind participants or healthcare personnel to the randomized treatment arm, this likely would not introduce bias in the objective measurement of the outcome of mortality; however, it was considered as a risk of bias for more subjectively measured outcomes, clinical deterioration, along with the total body of evidence contributing to those outcomes (Table 11). There are limited safety data in the preliminary report.

Both RECOVERY and Randomized, Embedded, Multifactorial Adaptive Platform Trial for Community Acquired Pneumonia (REMAP-CAP) (the 2 tocilizumab trials that reported a benefit) initiated treatment early (randomization at a median of 2 days of hospitalization in RECOVERY; <24 hours in the intensive care unit [ICU] for REMAP-CAP), suggesting tocilizumab may be more beneficial early in people with rapidly progressive disease.

Sarilumab. We identified 3 RCTs that reported on patients with severe or critical COVID-19 randomized to treatment with sarilumab or placebo/usual care [106, 114, 115]. In addition, a preprint network meta-analysis of 18 RCTs was identified that reported network estimates for sarilumab plus corticosteroids compared with usual care alone [116].

Benefits

Tocilizumab. Among hospitalized patients, tocilizumab showed a trend toward reduced mortality at 28 days compared with no tocilizumab treatment (RR: .91; 95% CI: .79, 1.04; moderate CoE). Tocilizumab demonstrated a lower relative risk of clinical deterioration, defined as death, need for mechanical ventilation, ECMO, or ICU admission, compared with placebo/usual care (RR: .83; 95% CI: .77, .89; moderate CoE). Four studies were not blinded, while in the remaining 3 trials healthcare personnel and outcome assessors were blinded. The panel noted that tocilizumab causes a decline in CRP levels, which, if obtained, would reveal the treatment arm designations of the patients, therefore introducing bias for the more subjectively measured outcomes of clinical deterioration and serious adverse events.

Sarilumab. Among hospitalized patients, sarilumab showed a trend toward reduced mortality at 28 days compared with usual care (network estimate OR: .80; 95% CI: .61, 1.04; low CoE). Sarilumab may reduce clinical deterioration, defined as progression to intubation, ECMO, or death, compared with usual care (RR: .67; 95% CI: .42, 1.05; very low CoE).

Harms

Serious adverse events among patients receiving tocilizumab or sarilumab did not differ from those receiving usual care (RR: .89; 95% CI: .74, 1.07 [low CoE]; and RR: 1.03; 95% CI: .89, 1.18 [low CoE], respectively). An additional trial attributed treatment with tocilizumab to 3 serious adverse events; however, it did not report events among patients not receiving tocilizumab [108]. Previously, tocilizumab has been associated with gastrointestinal perforations in non–COVID-19 settings, and case reports of bowel perforations have recently emerged with the use of tocilizumab for COVID-19 [117–120]. Increased infection risks have been noted in uncontrolled studies, and it is possible that this risk may be compounded by the combination of glucocorticoids and tocilizumab [121, 122].

Other Considerations

While the overall CoE for the trend toward a reduction in mortality was moderate, the panel believes that differences in mortality rates across the trials may be the result of the differences in baseline severity of study participants and timing of tocilizumab receipt in the disease course. In REMAP-CAP, tocilizumab was administered within 24 hours of participants initiating organ support in an ICU, raising the possibility that this may be the optimal time to administer the drug. In RECOVERY, tocilizumab was administered to participants with oxygen saturation of less than 92% on room air or receiving oxygen therapy and CRP ≥75 mg/L. Given the reduction in clinical deterioration and trend toward mortality reduction, the guideline panel made a conditional recommendation for treatment of adults with tocilizumab.

The use of tocilizumab, as with other therapeutic agents that can suppress the immune system, presents additional considerations and potential concerns when used in immunocompromised hosts. The panel did not conduct an analysis of available data to assess differences in efficacy and/or adverse effects of tocilizumab among oncology or other immunocompromised patients at this time.

The panel recognized the current shortage of tocilizumab and possible net benefit of treatment with sarilumab.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests tocilizumab for hospitalized adults with COVID-19. When tocilizumab is not available and baricitinib is either not appropriate or available, the guideline panel suggests sarilumab for persons who would otherwise qualify for tocilizumab; however, it is acknowledged that patients, particularly those responding to steroids alone or baricitinib, who put a high value on avoiding the possible adverse events of sarilumab and a low value on the uncertain mortality reduction, would reasonably decline sarilumab.

Additional research is needed to understand the efficacy of tocilizumab when taken at different times during the course of disease. For example, there are no data to guide recommendations in patient younger than 18 years of age at this time. In addition, future studies are needed to inform the generalizability of tocilizumab with different IL-6 receptor inhibitors for patients with COVID-19 (Supplementary Table 2). At the time of update, preliminary data from a trial of treatment with sarilumab have been shared as a preprint [106]; however, the number of patients who received sarilumab is limited (n = 45) and the published manuscript was not available for analysis or inclusion to inform this recommendation. Other studies of sarilumab have not been made available (Table 12).

Convalescent Plasma

Section last reviewed and updated 3 February 2022
Last literature search conducted 31 January 2022

Recommendation 13: Among patients hospitalized with COVID-19, the IDSA guideline panel recommends against COVID-19 convalescent plasma. (strong recommendation, moderate certainty of evidence)

Recommendation 14: Among ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease who have no other treatment options*, the IDSA guideline panel suggests FDA-qualified high-titer COVID-19 convalescent plasma within 8 days of symptom onset rather than no high-titer COVID-19 convalescent plasma. (conditional recommendation†, low certainty of evidence)

Remarks:

Table 11. GRADE Evidence Profile, Recommendation 11—Question: Tocilizumab Compared to No Tocilizumab for Hospitalized Patients With COVID-19 (*Last Updated 17 February 2021; Last Reviewed 14 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Tocilizumab	No Tocilizumab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: range 28 days to 30 days)												
8 [106–113]	randomized trials	not serious[a]	not serious	not serious	serious[b]	none	810/3280 (24.7%)	893/3054 (29.2%)	**RR 0.91** (.79 to 1.04)	**26 fewer per 1000** (from 61 fewer to 12 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Clinical deterioration (follow-up: range 14 days to 30 days)												
7 [106–112]	randomized trials	serious[c]	not serious	not serious[d]	not serious	none	799/2712 (29.5%)	939/2503 (37.5%)	**RR 0.83** (.77 to .89)	**64 fewer per 1000** (from 86 fewer to 41 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events												
7 [106, 107, 109–113][e]	randomized trials	serious[c]	not serious	not serious	serious[f]	none	210/1249 (16.8%)	141/946 (14.9%)	**RR 0.89** (.74 to 1.07)	**16 fewer per 1000** (from 39 fewer to 10 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Although some studies did not blind participants or investigators, this is unlikely to affect the mortality outcome.

[b]95% CI includes benefits as well as harms.

[c]Some studies lacked blinding and due to the mechanism of tocilizumab (reduction in inflammatory marker), unblinding likely occurred in the blinded studies.

[d]Definition of clinical deterioration varied, with all studies including need for ventilation and death, but other studies included need for intensive care unit admission (2 studies) or PaO_2:FiO_2 ratio of <150 mmHg (1 study).

[e]The 95% CI includes both potential for harm as well as benefit; few events reported do not meet the optimal information size and suggest fragility in the estimate.

[f]The 95% CI includes both potential for harm as well as benefit; Few events reported do not meet the optimal information size and suggest fragility in the estimate.

Table 12. GRADE Evidence Profile, Recommendation 12—Question: Sarilumab Compared to No Sarilumab for Hospitalized Patients With COVID-19 (*Last Reviewed and Updated 14 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Sarilumab	No Sarilumab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (assessed with indirect estimate from network meta-analysis)												
18 [116][a]	randomized trials	not serious	not serious	not serious	very serious[b]	none	Network estimate: **OR: .80**; 95%: CI: .61, 1.04 Direct estimate: **OR: .98**; 95% CI: .62, 1.56 Indirect estimate: **OR: .72**; 95% CI: .52, .99				⊕⊕◯◯ LOW	CRITICAL
Clinical deterioration (follow-up: 21 days; assessed with progression to intubation, ECMO, or death)												
2 [106, 114]	randomized trials	serious[c]	not serious[d]	not serious[e]	very serious[f]	none	72/305 (23.6%)	157/341 (46.0%)[g]	**RR 0.67** (.42 to 1.05)	**152 fewer per 1000** (from 267 fewer to 23 more)	⊕◯◯◯ VERY LOW	CRITICAL
Serious adverse events (follow-up: 21 days)												
4 [106, 114, 115]	randomized trials	serious	not serious	not serious	serious[h]	none	566/1520 (37.2%)	158/795 (19.9%)	**RR 1.03** (.89 to 1.18)	**6 more per 1000** (from 22 fewer to 36 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ECMO, extracorporeal membrane oxygenation; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; OR, odds ratio; RR, risk ratio.

[a]Eighteen trials included in the network.

[b]The direct network estimate crosses the line of no effect; however, the indirect estimate in the network demonstrates a trend toward mortality reduction when sarilumab + corticosteroids rather than corticosteroids alone are given. Few events reported in the direct network estimate suggesting fragility.

[c]Lack of blinding of study personnel, participants, and outcome assessors.

[d]Substantial heterogeneity present ($I^2 = 57\%$); however, likely contributes to the wide CI and accounted for within imprecision.

[e]Definition of clinical deterioration varied, with all studies including need for ventilation; however, 1 study included ECMO and death and the other study included use of high-flow cannula.

[f]95% CI cannot exclude the possibility of harm. Few events suggest fragility of the estimate.

[g]Analysis includes participants free of invasive mechanical ventilation at baseline for Gordon and patients free of high-flow cannula at baseline.

[h]95% CI cannot exclude the possibility of harms.

- In the United States, FDA EUA only authorizes use in patients with immunosuppressive disease or receiving immunosuppressive treatment.
- Patients, particularly those who are not immunocompromised, who place a low value on the uncertain benefits (reduction in the need for mechanical ventilation, hospitalization, and death) and a high value on avoiding possible adverse events associated with convalescent plasma, would reasonably decline convalescent plasma.

**Other options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, symptom duration, renal function, drug interactions) as well as product availability should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.*

†The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.

Why Is Convalescent Plasma Considered for Treatment?

Convalescent plasma has been used as passive immunotherapy for the prevention and treatment of infections for over 100 years [123, 124]. The predominant proposed protective mechanism is thought to be pathogen neutralization, although antibody-dependent cellular cytotoxicity and enhanced phagocytosis may also play a role. With the advent of effective antimicrobial therapy (ie, "the antibiotic era"), convalescent plasma fell out of favor. In recent years, interest in this approach has been revived as a means of addressing viral epidemics such as Ebola, SARS-CoV-1, and MERS. Studies of convalescent plasma derived from people who had recovered from those specific infections showed encouraging results but were typically small, nonrandomized, and largely descriptive [125–127]. In the current pandemic, convalescent plasma obtained from individuals who have recovered from COVID-19 has been used in over 100 000 patients with moderate to severe infection as part of an expanded-access program [128, 129]. In an analysis of the convalescent plasma expanded-access program, higher levels of antibodies were associated with significant improvements in mortality compared with those receiving convalescent plasma with lower concentrations of neutralizing antibodies [128]. However, there was no placebo group in the study, so this result could be from increased mortality with low antibody titer plasma rather than improved mortality with high antibody titer plasma. Subgroup data from 1 open-label RCT reporting on plasma with anti–receptor-binding domain enzyme-linked immunosorbent assay (ELISA) values corresponding to a high antibody titer cutoff resulted in a nonsignificant relative risk reduction in mortality of 5% (RR: .95; 95% CI: .73, 1.25) [130]. An additional subgroup analysis suggested unselected convalescent plasma (ie, not limited to high-titer antibodies) may increase the relative risk for mortality by 49% (RR: 1.42; 95% CI: .92, 1.69).

An analysis of the convalescent plasma expanded-access program suggests the most benefit is seen when convalescent plasma is given in the first 3 days from diagnosis [128]. In August 2020, the FDA issued an EUA for investigational convalescent plasma for the treatment of COVID-19 in hospitalized patients [131]. In early February 2021, the FDA issued a revision to the EUA to limit the authorization to the use of high-titer COVID-19 convalescent plasma for the treatment of hospitalized patients early in the disease course [132].

Summary of the Evidence

Our search identified and was informed by evidence from 21 RCTs and a large (n = 20 000), single-arm registry study [123–127, 133–142], as they provided the best available evidence for the outcomes of mortality, need for mechanical ventilation, serious adverse events, and adverse events. Eighteen of those RCTs reported on convalescent plasma infusions for patients hospitalized with COVID-19 (Table 13) [123–126, 133–138] and 3 RCTs [140–142] reported on receipt of convalescent plasma by ambulatory persons with mild COVID-19 disease (Table 14) [127].

Eighteen trials randomized 17 232 patients hospitalized with COVID-19 to receive COVID-19 convalescent plasma infusion [123–126, 133–138]. Several trials were open-label and/or had concerns with risk of bias due to lack of adjustment for critical confounders or potential for residual confounding (Supplementary Table 16a). The timing of receipt of COVID-19 convalescent plasma during the clinical course of the patients' illness varied across studies (Supplementary Table 15). One trial reported on 160 persons who received high-titer convalescent plasma less than 72 hours after the onset of symptoms of COVID-19 (mean age: 77.2 years; standard deviation: ±8.6 years) [127]. In addition, an observational study [139] reported on safety outcomes of over 20 000 patients enrolled in the same FDA expanded-access program for COVID-19 convalescent plasma study.

Benefits

Hospitalized. In hospitalized patients, convalescent plasma transfusion appears to have trivial or no effect on mortality based on the body of evidence from RCTs (RR: .98; 95% CI: .93, 1.03; moderate CoE). Recipients of COVID-19 convalescent plasma may have a greater need for mechanical ventilation (RR: 1.10; 95% CI: .94, 1.29; low CoE); however, the evidence is uncertain because of concerns with risk-of-bias imprecision.

Ambulatory. Receipt of COVID-19 convalescent plasma showed a reduction in hospitalization (RR: .74; 95% CI: .56,

Table 13. GRADE Evidence Profile, Recommendation 13—Question: Convalescent Plasma Compared to No Convalescent Plasma for Hospitalized Patients With COVID-19 (*Last Reviewed and Updated 4 November 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Convalescent Plasma	No Convalescent Plasma	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (RCTs) (follow-up: range 15 days to 60 days)												
18 [123–126, 130, 133–138, 149–155]	randomized trials	not serious[a,b]	not serious	not serious	serious[c]	none	2163/9082 (23.8%)	2007/8150 (24.6%)	**RR 0.98** (.93 to 1.03)	**5 fewer per 1000** (from 17 fewer to 7 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Need for mechanical ventilation												
4 [125, 134, 137, 151]	randomized trials	serious[d]	not serious	not serious	serious[e]	none	184/581 (31.7%)	166/471 (35.2%)	**RR 1.10** (.94 to 1.29)	**35 more per 1000** (from 21 fewer to 102 more)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (transfusion-associated circulatory overload, transfusion-related acute lung injury, severe allergic transfusion reaction) (follow-up: 4 hours)												
1 [139]	observational studies	extremely serious[f]	not serious	not serious	not serious	none	SAEs from 20 000 transfused patients: Within first 4 hours, of the SAEs, 63 deaths were reported (0.3% of all transfusions) and 13 of those deaths were judged as possibly or probably related to the transfusion of COVID-19 convalescent plasma. There were 83 non-death SAEs reported, with 37 reports of transfusion-associated circulatory overload (TACO), 20 reports of transfusion-related acute lung injury (TRALI), and 26 reports of severe allergic transfusion reaction.				⊕◯◯◯ VERY LOW	CRITICAL
Serious adverse events (mortality, cardiac, thrombotic, sustained hypotensive events requiring intervention) (follow-up: 7 days)												
1 [139]	observational studies	extremely serious[f]	not serious	not serious	not serious	none	SAEs from 20 000 transfused patients: Within 7 days of transfusion, 1711 deaths (8.56%) and 1136 serious adverse events (5.68%) were reported. Non-mortality SAEs included: 643 cardiac events (569 judged as unrelated to the transfusion); 406 sustained hypotensive events requiring intravenous pressor support; and 87 thromboembolic or thrombotic events (55 judged as unrelated to the transfusion).				⊕◯◯◯ VERY LOW	CRITICAL

Table 13. Continued

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Convalescent Plasma	No Convalescent Plasma	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Any adverse events (RCTs)												
11 [125, 126, 130, 134, 136, 139, 149, 150, 152–155]	randomized trials	serious[d]	not serious	not serious[g]	serious[h]	none	574/2843 (20.2%)	307/1959 (15.7%)	**RR 1.08** (.94 to 1.26)	**13 more per 1000** (from 9 fewer to 41 more)	⊕⊕◯◯ LOW	IMPORTANT

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RCT, randomized controlled trial; RR, risk ratio; SAE, serious adverse event.

[a]Li et al [123] time between symptom onset and randomization was over 14 days for >90% (median 30 days), no adjustment for co-interventions, allocation concealment methods not reported, and participants and healthcare professionals not blinded.

[b]Many trials had concerns due to open-label trial, allocation concealment not reported, and no adjustments for co-interventions.

[c]The 95% CI includes the potential for appreciable benefit; however, cannot exclude the potential for no effect.

[d]Concerns include open-label trial design and assessment of outcome.

[e]The 95% CI may not include a clinically meaningful reduction in need for mechanical ventilation.

[f]No comparative effects available. Some subjectivity in classification of outcomes as transfusion related.

[g]Lack of standard definition for adverse events. Studies report on mild to severe events.

[h]The 95% CI includes the potential for both increased harms, as well as no increased harms. Few events suggests fragility of the estimate.

Table 14. GRADE Evidence Profile, Recommendation 14—Question: Convalescent Plasma Compared to No Convalescent Plasma for Ambulatory Patients With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 21 January 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Convalescent Plasma	No Convalescent Plasma	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
All-cause mortality (follow-up: range 15 days to 28 days)[a]												
3 [140–142]	randomized trials	not serious	not serious	not serious	very serious[b]	none	3/929 (0.3%)	7/923 (0.8%)	**RR 0.53** (.14 to 1.98)	**4 fewer per 1000** (from 7 fewer to 7 more)	⊕⊕◯◯ LOW	CRITICAL
COVID-19–related hospitalizations, ED/urgent care visits, or death (follow-up: 15 days)												
2 [140, 142]	randomized trials	not serious	not serious	not serious	serious[c]	none	94/849 (11.1%)	118/843 (14.0%)	**RR 0.79** (.62 to 1.00)	**29 fewer per 1000** (from 53 fewer to 0 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalizations (all-cause) (follow-up: range 15 days to 28 days)												
2 [140, 142]	randomized trials	not serious	not serious	not serious	serious[d]	none	73/867 (8.4%)	98/869 (11.3%)	**RR 0.74** (.56 to .98)	**29 fewer per 1000** (from 50 fewer to 2 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Progression to severe respiratory disease (follow-up: 15 days; assessed with: defined as a respiratory rate of ≥30 breaths per minute, SaO_2 < 93% on room air, or both)												
1 [141]	randomized trials	not serious[e]	not serious	serious[f]	serious[g]	none	13/80 (16.3%)	25/80 (31.3%)	**RR 0.52** (.29 to .94)	**150 fewer per 1000** (from 222 fewer to 19 fewer)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events: serious transfusion reactions (requiring treatment or admission) (follow-up: 15 days)												
2 [140, 142]	randomized trials	not serious	not serious	not serious	very serious[c]	none	5/849 (0.6%)	0/843 (0.0%)	**RR 5.95** (.72 to 49.29)[h]	**6 more per 1000** (from 1 more to 11 more)[i]	⊕⊕◯◯ LOW	CRITICAL
Any adverse events (follow-up: 15 days)												
2 [140, 142]	randomized trials	not serious	not serious	not serious	serious[c]	none	127/849 (15.0%)	147/843 (17.4%)	**RR 0.86** (.70 to 1.05)	**24 fewer per 1000** (from 52 fewer to 9 more)	⊕⊕⊕◯ MODERATE	IMPORTANT

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ED, emergency department; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio; SaO_2, saturated oxygen.

[a]Deaths beyond 15 days and up to 30 days: an additional 5 deaths occurred in the plasma group and 1 death in placebo (normal saline) group.

[b]Only 1 event.

[c]95% CI includes benefits as well as harms; Optimal Information Size (OIS) not met.

[d]Few events reported. 95% CI may not include clinically meaningful benefit.

[e]Trial was terminated early due to futility.

[f]Oxygenation and respiration rates are surrogate measures of need for ventilation, morbidity, and death.

[g]Few events reported do not meet the optimal information size and suggest fragility of the estimate.

[h]Using 0.5 event continuity correction.

[i]Zero events in the control group. Absolute risk difference not informed by relative risk.

.98; moderate CoE) and a trend toward a reduction in COVID-19–related hospitalizations or medically attended visits (emergency room or urgent care; RR: .79; 95% CI: .63, 1.00; moderate CoE); however, the evidence remains uncertain due to few events reported. Similarly, evidence showed a possible reduction of progression to severe respiratory disease (RR: .52; 95% CI: .29, .94; low CoE); however, the evidence remains uncertain, as oxygenation and respiration rates are surrogate measures of need for ventilation, morbidity, and death, and because of the fragility of the estimate due to the small number of events reported. Convalescent plasma transfusion failed to show or exclude a beneficial effect on all-cause mortality based on the body of evidence from 2 RCTs (RR: .53; 95% CI: .14, 1.98; low CoE); however, the evidence is uncertain due to concerns with fragility of the estimate due to the small number of events reported. Additional deaths beyond 15 days were reported in 1 RCT and included 5 deaths in the plasma group versus 1 death in the placebo arm.

Harms

In the largest safety study (n = 20 000), within 4 hours of completion of convalescent plasma transfusion, the authors reported 146 serious adverse events classified as transfusion reactions (<1% of all transfusions) [139]. Of these, 63 deaths were reported (0.3%), with 13 judged as possibly or probably related to the transfusion. The non-mortality serious adverse events include 37 reports of transfusion-associated circulatory overload, 20 cases of transfusion-related acute lung injury, and 26 cases of severe allergic transfusion reactions.

Within 7 days of transfusion, 1711 deaths were reported (mortality rate: 8.56%; 95% CI: 8.18%, 8.95%). In addition, 1136 serious adverse events were reported: 643 cardiac events (569 judged as unrelated to the transfusion), 406 sustained hypotensive events requiring IV pressor support, and 87 thromboembolic or thrombotic events (55 judged as unrelated to the transfusion).

Eleven trials among patients hospitalized for COVID-19 suggest increased adverse events among patients receiving convalescent plasma (RR: 1.08; 95% CI: .94, 1.26; low CoE); however, the evidence was uncertain due to concerns with lack of blinding. In addition, included studies lacked a standard definition for what met the definition of an adverse event. In ambulatory patients, serious adverse events were higher in the convalescent plasma group due to serious transfusion reactions requiring treatment or admission (RR: 5.95; 95% CI: .72, 49.29; low CoE), although the evidence is uncertain due to few events.

Other Considerations

Hospitalized Patients. The panel agreed that the overall CoE is moderate due to some remaining imprecision as the 95% CI crossed the threshold of 1% for plausible mortality reduction. The guideline panel recognized that unselected use of convalescent plasma appeared to have trivial to no beneficial effect from the now-existing large body of evidence.

Ambulatory Persons. The panel agreed that the overall CoE is low due to concerns with imprecision, which recognized the limited events and concerns with fragility. The guideline panel recognized the inability to exclude a meaningful beneficial or detrimental effect when plasma is given early in the course of COVID-19 disease.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests against COVID-19 convalescent plasma for persons hospitalized with COVID-19. Based on limited studies and mechanistic reasoning, COVID-19 convalescent plasma may be more effective if given at high titers early in the course of hospitalization, in patients with undetectable or low levels of anti–SARS-CoV-2 antibodies, or in those with a humoral immune deficiency [143–148]. Current RCTs have not reported outcomes in such prespecified subpopulations. Future studies in hospitalized patients should focus on patients with humoral immunodeficiencies early in the course of COVID-19. Future studies in hospitalized patients should also consider screening for SARS-CoV-2 neutralizing antibodies in all patients at entry into RCTs and assessing outcomes based on antibody levels.

The guideline panel suggests FDA-qualified, high-titer COVID-19 convalescent plasma in the ambulatory setting for persons with mild-to-moderate COVID-19 at high risk for progression to severe disease, who have no other treatment options. In ambulatory patients, convalescent plasma may be more effective if the product used contains high titers of neutralizing antibodies and is used early in clinical presentation or in subpopulations of patients who do not have an adequate humoral immune response even at later stages of disease [143]. There is a paucity of trials in this specific population of patients. Future studies in ambulatory patients should target these populations.

Additional clinical trials may be needed to also determine whether there is a benefit of treatment with COVID-19 convalescent plasma and at what dose (neutralizing antibody titers), especially for patients early in the disease course of COVID-19 (Supplementary Table 2).

Remdesivir

Section last reviewed and updated 7 February 2022
Last literature search conducted 31 January 2022

Recommendation 15: Among patients (ambulatory or hospitalized) with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel suggests remdesivir be initiated within 7 days of symptom onset rather than no remdesivir. (conditional recommendation†, low certainty of evidence)

Remarks:

- Dosing for remdesivir in mild-to-moderate COVID-19 is 200 mg on day 1 followed by 100 mg on days 2 and 3. Pediatric dosing is 5 mg/kg on day 1 and 2.5 mg/kg on subsequent days.
- Options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, molnupiravir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, patient age, symptom duration, renal function, drug interactions), product availability, and institutional capacity and infrastructure should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.

Recommendation 16: In patients on supplemental oxygen but not on mechanical ventilation or ECMO, the IDSA panel suggests treatment with 5 days of remdesivir rather than 10 days of remdesivir. (conditional recommendation†, low certainty of evidence)

Recommendation 17a: In hospitalized patients with severe* COVID-19, the IDSA panel suggests remdesivir over no antiviral treatment. (conditional recommendation†, moderate certainty of evidence)

Recommendation 17b: In patients with COVID-19 on invasive ventilation and/or ECMO, the IDSA panel suggests against the routine initiation of remdesivir (conditional recommendation††, very low certainty of evidence)

***Severity definitions*:**

**Severe illness is defined as patients with $SpO_2 \leq 94\%$ on room air.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Remdesivir Considered for Treatment?

Remdesivir (GS-5734) is an antiviral drug with potent in vitro activity against a range of RNA viruses including MERS-CoV and SARS-CoV-1 and -2 [156–158]. Remdesivir acts by causing premature termination of viral RNA transcription [158]. Its use improved disease outcomes and reduced viral loads in SARS-CoV-1–infected mice [157]. In rhesus macaques, therapeutic treatment with remdesivir showed reduction in SARS-CoV-2 loads, pathologic changes, and progression of clinical disease [159]. In this same animal model, remdesivir treatment initiated 12 hours postinoculation reduced clinical signs and virus replication in the lungs, and decreased the presence and severity of lung lesions.

Summary of the Evidence

Patients With Mild-to-Moderate Disease Who Are at High Risk for Progression to Severe COVID-19. One RCT compared treatment with 3 days of IV remdesivir (200 mg on day 1 followed by 100 mg on days 2 and 3) initiated within 7 days of symptom onset or no remdesivir in unvaccinated patients [160]. The study enrolled patients at high risk for progression (eg, obesity, diabetes mellitus, hypertension, immune compromise, etc) or aged 60 years or older who were symptomatic 7 days or less without prior treatment (eg, monoclonal antibodies) but were not expected to receive oxygen at time of enrollment (>94% on room air). The outcomes assessed were mortality, hospitalizations for any cause, and COVID-19–related medically attended visits as well as serious adverse events (Table 15).

Hospitalized Patients With $SpO_2 \leq 94\%$ on Room Air. Three RCTs comparing treatment with remdesivir (200 mg day 1, 100 mg daily days 2–10) against no remdesivir treatment [32, 161, 162] and 1 RCT comparing 5 days of treatment (200 mg day 1, 100 mg daily days 2–5) against 10 days (200 mg day 1, 100 mg daily days 2–10) of treatment [163] served as the best available evidence among hospitalized persons with severe COVID-19 (Tables 16–18). The outcomes assessed were mortality, time to clinical improvement, need for mechanical ventilation, serious adverse events, and adverse events leading to treatment discontinuation.

All trials used different definitions of severe disease for participants. The Adaptive COVID-19 Treatment Trial (ACCT) participants were considered to have severe disease if they required mechanical ventilation, supplemental oxygen, if SpO_2 was 94% or lower while breathing ambient air, or if they had tachypnea (respiratory rate ≥24 breaths per minute) [161]. Within the SOLIDARITY (https://clinicaltrials.gov/ct2/show/NCT04647669) trial (available only as a preprint at this time), participants with severe disease were receiving mechanical ventilation [32]. In study by Wang et al. [162], participants with severe disease had an SpO_2 ≤94% while breathing room air or a ratio of arterial oxygen partial pressure to fractional inspired O_2 ≤300 mm Hg and radiologically confirmed pneumonia.

Updated analyses include the final analysis from the ACTT-1 and the interim analysis of the SOLIDARITY trial [32, 161]. SOLIDARITY reported mortality among persons remaining in the hospital up to the duration of the study; however, among patients discharged before the end of the study, mortality may not have been collected completely. The study by Wang et al [162] was stopped early due to lack of recruitment into the trial due to decreased incidence in China.

Table 15. GRADE Evidence Profile, Recommendation 15—Question: Remdesivir Compared to No Remdesivir for Ambulatory Patients at High Risk for Progression to Severe COVID-19 (*Last Updated 23 December 2021; Last Reviewed 7 February 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Remdesivir	No Remdesivir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
1 [160]	randomized trials	not serious	not serious	not serious	very serious[a]	none	0/279 (0.0%)	0/283 (0.0%)	not estimable	…	⊕⊕◯◯ LOW	CRITICAL
Hospitalization (all-cause) (follow-up: 28 days)												
1 [160]	randomised trials	not serious	not serious	not serious	very serious[b]	none	5/279 (1.8%)	18/283 (6.4%)	**HR 0.28** (.10 to .75)	**45 fewer per 1000** (from 57 fewer to 16 fewer)	⊕⊕◯◯ LOW	CRITICAL
COVID-19–related medically attended visits (follow-up: 28 days)												
1 [160]	randomized trials	not serious	not serious	not serious	very serious[b]	none	4/246 (1.6%)	21/252 (8.3%)	**HR 0.19** (.07 to .56)	**67 fewer per 1000** (from 77 fewer to 36 fewer)	⊕⊕◯◯ LOW	IMPORTANT
Serious adverse events												
1 [160]	randomized trials	not serious	not serious	not serious	serious[b]	none	5/279 (1.8%)	19/283 (6.7%)	**RR 0.27** (.10 to .70)	**49 fewer per 1000** (from 60 fewer to 20 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; RR, risk ratio.

[a]Zero events and relatively small sample size (less than half the patients of the planned sample size were enrolled).

[b]Few events do not meet the optimal information size and suggest fragility in the estimate (less than half the patients of the planned sample size were enrolled).

Table 16. GRADE Evidence Profile, Recommendation 16—Question: Remdesivir 5 Days Compared to Remdesivir 10 Days for Hospitalized Patients With Severe But Not Critical COVID-19 (*Last Updated 10 September 2020; Last Reviewed 16 May 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Remdesivir 5 Days	Remdesivir 10 Days	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality												
1 [163]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	16/200 (8.0%)	21/197 (10.7%)	**HR 0.75** (.40 to 1.39)	**27 fewer per 1000** (from 64 fewer to 42 more)	⊕⊕◯◯ LOW	CRITICAL
Clinical improvement at 14 days												
1 [163]	randomized trials	serious[a]	not serious	not serious	serious[c]	none	129/200 (64.5%)	107/197 (54.3%)	**RR 1.19** (1.01 to 1.40)	**103 more per 1000** (from 5 more to 217 more)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events												
1 [163]	randomized trials	serious[a]	not serious	not serious	serious[c]	none	42/200 (21.0%)	68/197 (34.5%)	**RR 0.61** (.44 to .85)	**135 fewer per 1000** (from 193 fewer to 52 fewer)	⊕⊕◯◯ LOW	CRITICAL
Adverse events leading to treatment discontinuation												
1 [163]	randomized trials	serious[a,d]	not serious	not serious	serious[c]	none	9/200 (4.5%)	20/197 (10.2%)	**RR 0.44** (.21 to .95)	**57 fewer per 1000** (from 80 fewer to 5 fewer)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; RR, risk ratio.

[a]Goldman et al [163] did not blind participants, healthcare workers, or outcome assessors. After randomization, disease severity was greater in the 10-day arm; while the analysis adjusted for baseline characteristics including disease severity, there is still the potential for residual confounding.

[b]The 95% CI includes the potential for both appreciable benefit, as well as appreciable harm. Few events reported do not meet the optimal information size and suggest fragility in the estimate.

[c]The lower boundary of the 95% CI may not include a clinically meaningful effect. Few events reported do not meet the optimal information size and suggest fragility in the estimate.

[d]Goldman et al [163] stratified adverse events by days 1–5, 6–10. Adverse events leading to treatment discontinuation during days 1–5 were 9 (4%) in the 5-day arm and 14 (7%) in the 10-day arm.

Table 17. GRADE Evidence Profile, Recommendation 17a—Question: Remdesivir Compared to No Antiviral Treatment for Hospitalized Patients With Severe COVID-19 (*Last Reviewed and Updated 16 May 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Remdesivir	No Remdesivir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: range 28 days to 29 days)												
3 [32, 161, 162]	randomized trials	serious[a,b,c]	not serious	not serious	serious[d]	none	369/2726 (13.5%)	374/2593 (14.4%)	**RR 0.92** (.77 to 1.10)	**12 fewer per 1000** (from 33 fewer to 14 more)	⊕⊕◯◯ LOW	CRITICAL
Time to recovery (follow-up: 29 days)												
1 [161]	randomized trials	serious[c]	not serious	not serious	not serious	none	345/486 (71.0%)	306/471 (65.0%)	**Rate ratio 1.31** (1.12 to 1.52)	**97 more per 1000** (from 41 more to 147 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Clinical improvement (follow-up: 28 days)												
1 [162]	randomized trials	not serious[a,b]	not serious	not serious	very serious[d]	none	103/158 (65.2%)	45/78 (57.7%)	**RR 1.13** (.91 to 1.41)	**75 more per 1000** (from 52 fewer to 237 more)	⊕⊕◯◯ LOW	CRITICAL
Need for mechanical ventilation (follow-up: 29 days)												
1 [161]	randomized trials	not serious	not serious	not serious	serious[e]	none	52/402 (12.9%)	82/364 (22.5%)	**RR 0.57** (.42 to .79)	**97 fewer per 1000** (from 131 fewer to 47 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events (grade 3/4)												
2 [161, 162]	randomized trials	not serious	not serious	not serious	serious[f]	none	44/632 (7.0%)	53/545 (8.9%)	**RR 0.79** (.54 to 1.16)	**20 fewer per 1000** (from 45 fewer to 16 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalization												
1 [162]	randomized trials	not serious[a,b]	not serious	not serious	very serious[d]	none	158	78	…	MD **1 day higher** (0.12 higher to 1.88 higher)	⊕⊕◯◯ LOW	IMPORTANT
Duration of mechanical ventilation												
1 [162]	randomized trials	not serious[a,b]	not serious	not serious	serious [d]	none	158	78	…	MD **8.5 day lower** (9.14 lower to 7.86 lower)	⊕⊕⊕◯ MODERATE	IMPORTANT

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; MD, mean difference; RR, risk ratio.

[a]Co-interventions received in Wang et al [162] include: interferon alpha-2b, lopinavir/ritonavir, vasopressors, antibiotics, and corticosteroid therapy and were balanced between arms.

[b]Wang et al [162] stopped early due to lack of recruitment. Trial initiated after reduction in new patient presentation (most patients enrolled later in the disease).

[c]Post hoc analysis of patients with severe disease from Pan et al [32] and Beigel et al [161] may introduce bias.

[d]The 95% CI may not include a clinically meaningful effect.

[e]Few events do not meet the optimal information size and suggest fragility in the estimate.

[f]The 95% CI cannot exclude the potential for benefit or harm. Also, few events do not meet the optimal information size.

Table 18. GRADE Evidence Profile, Recommendation 17b—Question: Remdesivir Compared to No Antiviral Treatment for Hospitalized Patients With Critical COVID-19 (IMV/ECMO) (*Last Updated 5 April 2021; Last Reviewed 16 May 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Remdesivir	No Remdesivir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: range 28 days to 29 days)												
2 [32, 161]	randomized trials	serious[a]	not serious	not serious	serious[b,c]	none	126/385 (32.7%)	100/387 (25.8%)	**RR 1.23** (.99 to 1.53)	**59 more per 1000** (from 3 fewer to 137 more)	⊕⊕◯◯ LOW	CRITICAL
Time to recovery (follow-up: 29 days)												
1 [161]	randomized trials	very serious[a]	not serious	not serious	very serious[d]	none	63/131 (48.1%)	77/154 (50.0%)	**HR 0.98** (.70 to 1.36)	**7 fewer per 1000** (from 116 fewer to 110 more)	⊕◯◯◯ VERY LOW	CRITICAL
Serious adverse events (grade 3/4)												
2 [161, 162]	randomized trials	not serious	not serious	not serious[e]	serious[d]	none	44/632 (7.0%)	53/545 (9.7%)	**RR 0.79** (.54 to 1.16)	**20 fewer per 1000** (from 45 fewer to 16 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ECMO, extracorporeal membrane oxygenation; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; IMV, invasive mechanical ventilation; RR, risk ratio.

[a]Post hoc analysis of patients with severe disease from Pan et al [32] and Beigel et al [161] may introduce bias.

[b]The 95% CI may not include a clinically meaningful effect.

[c] Optimal Information Size (OIS) for mortality: 1682.

[d]The 95% CI cannot exclude the potential for benefit or harm. Also, few events do not meet the optimal information size.

[e]Serious adverse events calculated from severe study groups in Beigel et al [161] and Wang et al [162], not invasive mechanical ventilation/ECMO subgroup.

Randomization performed in Goldman et al [163] failed to establish prognostic balance between baseline clinical status among the 397 patients randomized into the treatment arms, with patients in the 10-day arm more severely ill at study entry. Even with the adjusted analysis, residual confounding is possible. In addition, participants, healthcare workers, and outcome assessors were not blinded to the treatment arms.

Hospitalized Patients on Invasive Ventilation and/or ECMO. Subgroups from SOLIDARITY and ACTT-1 reported on the outcomes of mortality, time to recovery, and serious adverse events among patients on invasive ventilation or ECMO [32, 161] (Table 18). The duration of ventilation at time of treatment with remdesivir was not reported in ACTT-1. This may introduce uncertainty when assessing outcomes of mortality or time to recovery.

In ACTT-1 [161], randomization was stratified by study site and disease severity at enrollment. Disease severity groups were mild-to-moderate COVID-19 (SpO_2 >94%) and severe COVID-19 (SpO_2 ≤94%). The severe COVID-19 stratum included patients who were hypoxemic with various degrees of severity, including those requiring low-flow oxygen by nasal cannula and those needing high-flow oxygen, noninvasive ventilation, invasive mechanical ventilation, and ECMO. In addition to analyses on established strata, authors performed post hoc analyses for subgroups within the strata (eg, receiving oxygen, receiving high-flow oxygen or noninvasive mechanical ventilation, or receiving mechanical ventilation or ECMO), which may introduce concerns with risk of bias and imprecision when making inferences on the efficacy of remdesivir among these subgroups including mechanically ventilated patients.

Benefits

Patients With Mild-to-Moderate Disease Who Are at High Risk for Progression to Severe COVID-19. Treatment with remdesivir for 3 days in ambulatory patients reduced hospitalizations and COVID-19–related medically attended visits throughout day 28 (HR: .28; 95% CI: .1, .75 [low CoE]; and HR: 0.19; 95% CI: .07, .56 [low CoE], respectively). No deaths were observed.

Hospitalized Patients With SpO_2 ≤94% on Room Air. The pooled analysis failed to show a mortality benefit at 28 days (RR: .92; 95% CI: .77, 1.10; low CoE) [32, 161, 162]. Patients receiving treatment with remdesivir trend toward greater clinical improvement at 28 days than patients not receiving remdesivir (RR: 1.13; 95% CI: .91, 1.41; low CoE) [162]. In addition, based on a post hoc analysis of patients with severe COVID-19, receiving treatment with remdesivir had a shorter median time to recovery (median: 11 vs 18 days; rate ratio: 1.31; 95% CI: 1.12, 1.52; low CoE) and decreased need for mechanical ventilation (RR: .57; 95% CI: .42, .79; moderate CoE) [161].

In the study by Goldman et al [163] that compared 5 and 10 days of treatment, the shorter course of remdesivir showed a trend toward decreased mortality (RR: .75; 95% CI: .51, 1.12; low CoE) and increased clinical improvement at 14 days (RR: 1.19; 95% CI: 1.01, 1.40; low CoE); however, the evidence is uncertain because the persons in the 10-day group had more severe disease at baseline and there is the possibility of residual confounding despite the adjusted analysis.

Hospitalized Patients on Invasive Ventilation and/or ECMO. Treatment with remdesivir failed to show a reduction in mortality (RR: 1.23; 95% CI: .99, 1.53; low CoE). Similarly, remdesivir failed to show or exclude a reduction in time to recovery among patients on invasive ventilation and/or ECMO (HR: .98; 95% CI: .70, 1.36; very low CoE).

Harms

Patients With Mild-to-Moderate Disease Who Are at High Risk for Progression to Severe COVID-19. As with other remdesivir studies published so far, 3 days of remdesivir infusions did not appear to be associated with a greater risk of serious adverse events compared with no remdesivir (RR: .27; 95% CI: .1, .7; moderate CoE).

Hospitalized Patients With SpO_2 ≤94% on Room Air. Patients treated with remdesivir do not appear to experience greater serious adverse events (grade 3/4) than those not receiving remdesivir (RR: .87; 95% CI: .59, 1.28; moderate CoE) [161, 162].

Patients receiving 5 days of remdesivir may experience fewer serious adverse events and adverse events leading to treatment discontinuation than patients receiving 10 days of remdesivir (RR: .61; 95% CI: .44, .85 [low CoE]; and RR: .44; 95% CI: .21, .95 [low CoE], respectively); however, this evidence is uncertain because of the increased severity of disease among patients in the 10-day arm [163].

Hospitalized Patients on Invasive Ventilation and/or ECMO. Patients on invasive ventilation and/or ECMO treated with remdesivir do not appear to experience greater serious adverse events than those not receiving remdesivir (RR: .79; 95% CI: .54, 1.16; moderate CoE).

Other Considerations

Patients With Mild-to-Moderate Disease Who Are at High Risk for Progression to Severe COVID-19. The panel agreed that the overall CoE for the treatment of patients with mild-to-moderate COVID-19 was low due to concerns about imprecision, as less than half of the original projected sample size was enrolled, leading to few events and fragility of the effect estimate. However, compared with prior trials, giving remdesivir early in the course of the viral infection appears to have a robust effect within the limitation of a limited sample size. The panel

agreed that benefits are likely to outweigh any potential harms in patients with COVID-19 who are at high risk for severe disease. The evidence confirms that using remdesivir early in the disease process when viral loads are high confers maximum benefit. It is critical to make a rapid diagnosis and treat ambulatory patients with COVID-19 early in the disease course.

Hospitalized Patients With SpO_2 ≤94% on Room Air. The panel agreed that the overall CoE for treatment of persons with severe disease with remdesivir compared with no remdesivir treatment was moderate due to concerns with imprecision. Given the inconsistent definition used in the evidence to describe baseline severity, the panel recognized a knowledge gap when assessing whether greater benefit could be attained for patients with oxygen saturation greater than 94% and no supplemental oxygen; however, they agreed that the reported data supported the prioritization of remdesivir among persons with severe but not critical COVID-19.

The panel agreed on the overall CoE for treatment with a 5-day course compared with a 10-day course of treatment as low due to concerns with risk of bias and imprecision. The panel recognized the benefit of a shorter course of treatment, if providing similar or greater efficacy, on the availability of remdesivir. However, in a subgroup analysis of mechanically ventilated patients, the duration of treatment was 10 days in the ACCT-1 trial; therefore, the panel recognized that a longer course of treatment could be desirable in this population.

Hospitalized Patients on Invasive Ventilation and/or ECMO. The panel agreed on the overall CoE for treatment of patients on invasive ventilation and/or ECMO with remdesivir as very low due to concerns with risk of bias and imprecision. The panel recognized that the estimates of effect for mortality and time to recovery exclude almost any benefit.

Pediatric Use. The evidence for the use of remdesivir in children is limited. For ambulatory children at risk for severe disease, the RCT included 8 children aged 12 to 18 years, limiting our confidence in the available direct evidence for ambulatory care.

There are no randomized controlled data assessing the efficacy of remdesivir for the treatment of hospitalized pediatric patients with COVID-19. A report of 77 children who received remdesivir through compassionate use early in the pandemic found good tolerability in this population with a low rate of serious adverse events [164].

An ongoing study of remdesivir in children [165] is using 5 mg/kg on day 1 (maximum dose: 200 mg) followed by 2.5 mg/kg daily in patients over 14 days of age, gestational age more than 37 weeks, and weight greater than or equal to 2.5 kg. The FDA EUA applies to patients weighing over 3.5 kg and applies to the lyophilized powder formulation only.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests remdesivir for patients with mild-to-moderate disease who are at high risk for severe COVID-19.

The guideline panel suggests remdesivir rather than no remdesivir for the treatment of severe COVID-19 in hospitalized patients with SpO_2 ≤94% on room air. However, the guideline panel suggests against the routine initiation of remdesivir among patients on invasive ventilation and/or ECMO. Additional clinical trials are needed to provide increased certainty about the potential for both benefit and harms of treatment with remdesivir, as well as to understand the benefit of treatment based on disease severity.

Prescribing information in the United States recommends against the use of remdesivir in patients with an eGFR less than 30 mL per minute. This recommendation arises from concern about the accumulation of the excipient (betadex sulfobutyl ether sodium) in such patients with potential for hepatic and renal toxicity due to that substance. Additional research into the safety of remdesivir in patients with reduced renal function is needed to ascertain whether this concern is substantiated.

Immunocompromised patients who are unable to control viral replication may still benefit from remdesivir despite SpO_2 that exceeds 94% on room air or a requirement for mechanical ventilation. Management of immunocompromised patients with uncontrolled viral replication is a knowledge gap and additional research into such populations is needed.

In addition, research is needed to address gaps in the evidence of the effectiveness of remdesivir based on viral load.

Famotidine

Section last reviewed and updated 23 May 2022

Last literature search conducted 30 April 2022

Recommendation 18: Among ambulatory patients with mild-to-moderate COVID-19, the IDSA panel suggests against famotidine for the treatment of COVID-19 (conditional recommendation††, low certainty of evidence)

Recommendation 19: Among hospitalized patients with severe* COVID-19, the IDSA panel suggests against famotidine for the treatment of COVID-19. (conditional recommendation††, low certainty of evidence)

***Severity definitions*:**

**Severe illness is defined as patients with SpO_2 ≤94% on room air, including patients on supplemental oxygen.*

††The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the

Table 19. GRADE Evidence Profile, Recommendation 18—Question: Famotidine Compared to No Famotidine for Ambulatory Patients With Mild-to-Moderate COVID-19 (*Last Reviewed and Updated 17 May 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	High-Dose Famotidine (80 mg tid)	No Famotidine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Symptom resolution (follow-up: 28 days)[a]												
1 [168]	randomized trials	not serious	not serious	not serious	very serious[b]	none	19/27 (70.4%)[c]	18/28 (64.3%)	**RR 1.10** (0.76 to 1.58)	**64 more per 1000** (from 154 fewer to 373 more)	⊕⊕◯◯ LOW	CRITICAL
Adverse events[d]												
1 [168]	randomized trials	not serious	not serious	not serious	very serious[b]	none	2/27 (7.4%)	3/28 (10.7%)	**RR 0.69** (0.13 to 3.80)	**33 fewer per 1000** (from 93 fewer to 300 more)	⊕⊕◯◯ LOW	IMPORTANT

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Time to symptom resolution was the primary end point. However, the authors reported a faster (earlier) rate of symptom resolution with famotidine. No deaths were encountered.

[b]Sparse data, few events, and small sample size

[c]Only *P* value reported; number of events estimated from survival curve graph.

[d]No serious adverse events were encountered. Transaminase elevation in 1 patient in both arms; nausea/vomiting in 1 patient with famotidine; thrombocytopenia and hives in 1 patient each in the placebo group.

Table 20. GRADE Evidence Profile, Recommendation 19—Question: Famotidine Compared to No Famotidine for Hospitalized Patients With Severe COVID-19 (*Last Reviewed and Updated 17 May 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Famotidine	No Famotidine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality												
1 [169]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	8/89 (9.0%)	9/89 (10.1%)	**RR 0.89** (.36 to 2.20)	**11 fewer per 1000** (from 65 fewer to 121 more)	⊕⊕◯◯ LOW	CRITICAL
Mechanical ventilation												
1 [169]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	21/89 (23.6%)	24/89 (27.0%)	**RR 0.88** (.53 to 1.45)	**32 fewer per 1000** (from 127 fewer to 121 more)	⊕⊕◯◯ LOW	CRITICAL
ICU care												
1 [169]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	18/89 (20.2%)	20/89 (22.5%)	**RR 0.90** (.51 to 1.58)	**22 fewer per 1000** (from 110 fewer to 130 more)	⊕⊕◯◯ LOW	CRITICAL
Time to symptom free												
1 [169]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	89	89	…	MD **0.9 days fewer** (1.44 fewer to 0.36 fewer)	⊕⊕◯◯ LOW	IMPORTANT
Length of hospital stay												
1 [169]	randomized trials	serious[a]	not serious	not serious	serious[b]	none	89	89	…	MD **1.7 days fewer** (2.77 fewer to 1.13 fewer)	⊕⊕◯◯ LOW	IMPORTANT
Serious adverse events												
0	observational studies	…	…	…	…	…	Postmarketing and registrational reported common adverse events include constipation (1.2%–1.4%), diarrhea (1.7%), dizziness (1.3%), and headache (1%–4.7%), but overall famotidine is well tolerated. Rare but serious adverse events (<1%) include Stevens–Johnson syndrome, toxic epidermal necrolysis, necrotizing enterocolitis, anaphylaxis, angioedema, rhabdomyolysis, seizure, hospital-acquired pneumonia, interstitial pneumonia (Micromedex)			…	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; MD, mean difference; RR, risk ratio.

[a]Unclear allocation concealment in an unblinded study.

[b]Sparse data, small number of events or patients.

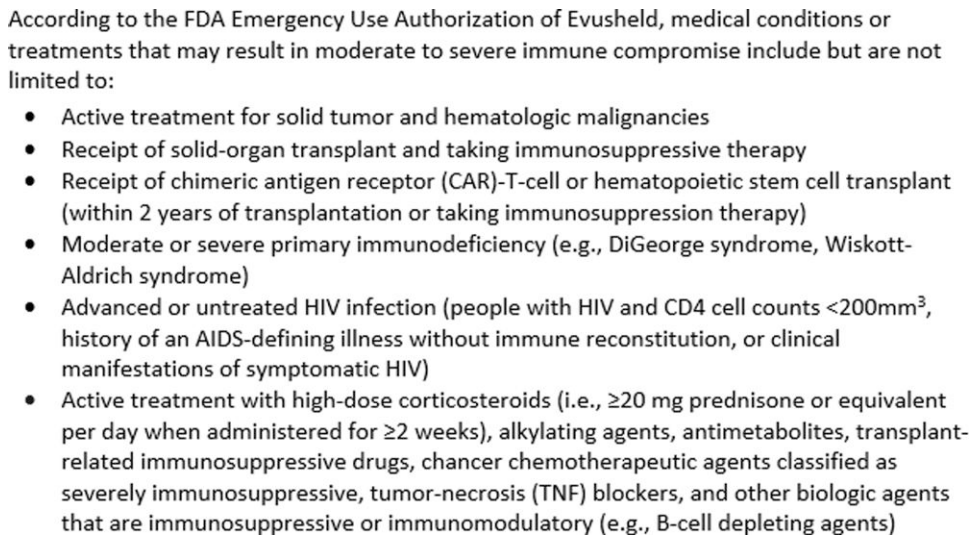

Figure 2. FDA EUA criteria for the use of tixagevimab/cilgavimab for pre-exposure prophylaxis of COVID-19 in moderately or severely immunocompromised patients [170]. Abbreviations: COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration; HIV, human immunodeficiency virus.

suggested course of action, while a substantial number would not.

Why Is Famotidine Considered for Treatment?

Anecdotal reports from China and a cohort study from the United States had suggested that patients infected with SARS-CoV-2 who were receiving famotidine, an H2-receptor antagonist used for conditions such as gastroesophageal reflux and peptic ulcer disease, had improved survival compared with those receiving proton pump inhibitors (PPIs) [166, 167]. This study led to interest in the drug, although no predominant theory describing a mechanism for its efficacy yet exists.

Our search identified 2 RCTs comparing treatment with famotidine against no famotidine among ambulatory persons with COVID-19 and persons hospitalized with severe COVID-19 [168, 169] (Tables 19 and 20).

Summary of the Evidence

Ambulatory Patients With Mild-to-Moderate Disease. One patient- and assessor-blinded RCT examined high-dose famotidine at 80 mg 3 times daily for 14 days (n = 27) versus placebo (n = 28) in a predominantly younger population (35 years) at average risk for progression to severe disease [168]. Symptom resolution was the primary endpoint.

Hospitalized Patients With Severe Disease. Oral famotidine at standard doses of 40 mg daily (n = 89) versus placebo (n = 89) was given to hospitalized patients with severe COVID-19 in an open-label RCT. The authors recorded symptom resolution, length of hospital stay, need for ICU care, need for mechanical ventilation, or death [169].

Benefits

Ambulatory Patients With Mild-to-Moderate Disease. Symptom resolution in ambulatory patients at day 28 failed to show or to exclude a beneficial effect of high-dose famotidine (RR: 1.1; 95% CI: .76, 1.58 [not directly reported but estimated from the survival curve]; low CoE).

Hospitalized Patients With Severe Disease. In hospitalized patients with severe COVID-19, famotidine at a standard dose failed to show or exclude a beneficial effect on mortality, need for mechanical ventilation, or need for ICU care (RR: .89; 95% CI: .36, 2.2; RR: .88; 95% CI: .53, 1.45; RR: 0.9; 95% CI: .51, 1.58, respectively; all low CoE). Time to symptom resolution was shorter in the famotidine group (mean difference [MD]: −.9 days; 95% CI: −1.44, −.36 days), as was length of hospital stay (MD: −1.7 days; 95% CI: −2.77, −1.13 days), although due to lack of blinding these estimates remain less certain (low CoE) (Table 20).

Harms

At standard doses, famotidine is well tolerated. Common adverse events include diarrhea or constipation but occur in less than 5% of people. Severe adverse events occur in less than 1% of persons taking famotidine. Adverse events were rare in the ambulatory study examining high-dose famotidine (RR: .69; 95% CI: .13, 3.8) and no severe adverse events were reported.

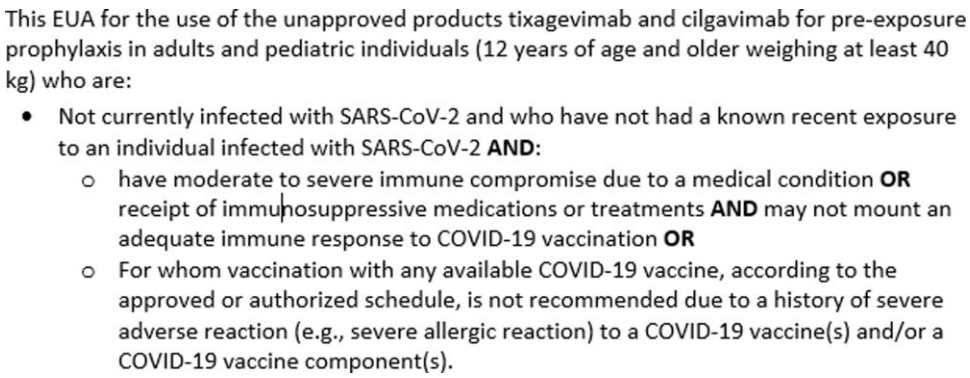

Figure 3. FDA EUA criteria for the use of tixagevimab/cilgavimab for pre-exposure prophylaxis of COVID-19 [170]. Abbreviations: COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

Other Considerations

The panel determined the CoE for ambulatory patients with mild-to-moderate disease to be low due to concerns with imprecision because of small sample sizes and few events.

The panel determined the CoE for hospitalized patients with severe disease to be low due to concerns with risk of bias and imprecision from small sample sizes and few events.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests against famotidine for the sole purpose of treating COVID-19. Clinical trials with larger sample sizes would be needed to determine the true effect of famotidine in patients with COVID-19 (Supplementary Table 2).

Neutralizing Antibodies for Pre-exposure and Postexposure Prophylaxis

Section last reviewed and updated 23 May 2022

Last literature search conducted 30 April 2022

Resources:

- Centers for Disease Control and Prevention (CDC): SARS-CoV-2 variants.
- FDA: Qualifications for SARS-CoV-2 exposure.
- FDA: EUA for tixagevimab co-packaged with cilgavimab.
- NIH: National Center for Advancing Translational Science.

Recommendation 20: In moderately or severely immunocompromised individuals* at increased risk for inadequate immune response to COVID-19 vaccine or for persons for whom COVID-19 vaccine is not recommended due to a documented serious adverse reaction to the vaccine, the IDSA guideline panel suggests pre-exposure prophylaxis with tixagevimab/cilgavimab rather than no tixagevimab/cilgavimab, when predominant regional variants are susceptible*** to the agent (conditional recommendation†, low certainty of evidence)**

Remarks:

- Dosing for tixagevimab/cilgavimab is 300 mg tixagevimab and 300 mg cilgavimab administered as 2 separate consecutive intramuscular injections once.

**See Figure 2.*

***For current information on circulating SARS-CoV-2 variants in the United States, please visit the CDC website.*

****For in vitro susceptibility information of SARS-CoV-2 variants, please visit Stanford University's Coronavirus Antiviral & Resistance Database* (Figure 3).

Recommendation 21: In persons exposed to COVID-19 who are at high risk of progression to severe COVID-19, the IDSA guideline panel suggests postexposure casirivimab/imdevimab only when predominant regional variants* are susceptible to the agent. (conditional recommendation†, low certainty of evidence)**

**For current information on circulating SARS-CoV-2 variants in the United States, please visit the CDC website.*

***For in vitro susceptibility information of SARS-CoV-2 variants, please visit Stanford University's Coronavirus Antiviral & Resistance Database.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Are Neutralizing Antibodies Considered for Prophylaxis?

Neutralizing antibodies directed at the receptor-binding domain of SARS-CoV-2 spike protein have been evaluated as prophylactic agents for COVID-19. In animal models there is

evidence that antibody therapy may more rapidly reduce viral load in the upper and lower airways of infected animals, resulting in reduced virus-induced pathology, demonstrating in vivo prophylactic and treatment efficacy [171, 172]. Additionally, antibody-mediated enhancement of disease, a theoretical adverse effect of neutralizing antibody prophylaxis, has not been detected in animal models or seen in clinical studies [172]. In a large randomized study of unvaccinated nursing home patients and staff where there was at least 1 confirmed case of COVID-19 at the facility, a single dose of bamlanivimab appeared to significantly reduce the incidence of "mild or worse" COVID-19 among the nursing home residents [173].

Potential advantages of neutralizing antibodies include the ability to standardize the amount of neutralizing activity and the possibility of conferring protection more rapidly than with vaccine-induced immune responses (which generally take several weeks).

As the pandemic progressed, new SARS-CoV-2 variants emerged with reduced neutralizing susceptibility to various anti–SARS-CoV-2 monoclonal antibodies (mAbs) in assays performed using infectious (also referred to as authentic) and pseudotyped viruses. For example, the first 2 authorized mAb combinations, bamlanivimab/etesevimab and casirivimab/imdevimab, have been found to be largely inactive against the Omicron BA.1 and BA.2 variants.

In a meta-analysis published as a preprint, the combination of tixagevimab/cilgavimab displayed a median 86-fold (IQR: 27–151-fold) reduction in activity against Omicron BA.1 in 15 studies and a median 5.4-fold (IQR: 3.7–6.9-fold) reduction in activity against Omicron BA.2 in 6 studies.

As a result of the reduced susceptibility of tixagevimab/cilgavimab to the BA.1 variant, the FDA recommended on 24 February 2022 that the dosage for each mAb in this combination be increased from 150 mg to 300 mg intramuscularly (Table 21).

Summary of the Evidence

Tixagevimab/Cilgavimab. Our search identified 1 RCT reporting on PrEP with a single dose of intramuscular tixagevimab/cilgavimab administration in adults 18 years of age and older who are at increased risk of inadequate response to COVID-19 vaccination or SARS-CoV-2 infection [170, 174]. Patients included were those that were either age 60 years and older, immunocompromised, had severe renal or liver impairment, chronic obstructive pulmonary disease (COPD), or those who had an increased risk of exposure including those working in healthcare or living in congregate living settings. All participants had a negative SARS-CoV-2 serology test result at screening, had no history of SARS-CoV-2 infection, and had not received vaccine or a biologic indicated for the prevention of SARS-CoV-2 or COVID-19. Study participants received a single combined 300-mg intramuscular dose of the combination of tixagevimab (150 mg)/cilgavimab (150 mg).

Casirivimab/Imdevimab. Our search identified 1 RCT reporting on PEP with neutralizing antibodies (combination of casirivimab/imdevimab) for patients exposed to COVID-19 who are at high risk of progression to severe disease [175] (Table 22).

One RCT reported on 1505 persons testing negative for SARS-CoV-2 infection (by reverse transcriptase–quantitative PCR assay [RT-qPCR]) within 96 hours following household contact with a diagnosis of SARS-CoV-2 infection [175]. Of those included in the trial, 30.5% of participants were categorized as having a high risk of COVID-19 (eg, ≥65 years of age, body mass index [BMI] ≥35 kg/m^2, chronic kidney disease, etc). Participants in the treatment group received a total dose of 1200 mg casirivimab/imdevimab subcutaneously.

Benefits

Tixagevimab/Cilgavimab. Pre-exposure prophylaxis with tixagevimab/cilgavimab appears to have little or no effect on mortality through a median of 6 months (RR: .50; 95% CI: .13, 2.0; absolute risk reduction: 1 fewer per 1000 [from 2 fewer to 2 more]; moderate CoE). Symptomatic COVID-19 infection within 6 months after administration was reduced in those who received tixagevimab/cilgavimab compared with placebo (RR: .18; 95% CI: .09, .35; moderate CoE).

Casirivimab/Imdevimab. Persons receiving PEP with casirivimab/imdevimab reduced symptomatic SARS-CoV-2 infection from 7.8% to 1.5% (RR: .19; 95% CI: .10, .35; moderate CoE). Of the 70 persons who developed symptomatic infection, those who received casirivimab/imdevimab rather than placebo experienced a shorter duration of symptoms (MD: −2.0 weeks; 95% CI: −2.91, −1.09 weeks; low CoE).

Harms

Tixagevimab/Cilgavimab. Serious adverse events were not meaningfully different in those who received PrEP with tixagevimab/cilgavimab compared with placebo (RR: 1.09; 95% CI: .67, 1.78; moderate CoE).

Casirivimab/Imdevimab. Serious treatment-emergent adverse events may be less frequent among persons receiving casirivimab/imdevimab compared with those receiving placebo; however, this may not be meaningfully different from those receiving placebo (RR: .66; 95% CI: .30, 1.47; low CoE).

Other Considerations

Tixagevimab/Cilgavimab. The panel agreed that the overall CoE for PrEP with tixagevimab/cilgavimab was low due to concerns with the generalizability of the trial population to the FDA-authorized indications (eg, immunocompromised persons) and low number of events (fragility of results). The panel noted concerns with feasibility at different centers given the

Table 21. GRADE Evidence Profile, Recommendation 20–Question: Tixagevimab/Cilgavimab Compared to No Tixagevimab/Cilgavimab for Pre-exposure Prophylaxis in Adults at Increased Risk for Inadequate Immune Response to COVID-19 Vaccine or For Whom COVID-19 Vaccine Is Not Recommended (*Last Reviewed and Updated 23 December 2021)*

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Tixagevimab/ Cilgavimab	No Tixagevimab/ Cilgavimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
All-cause mortality (follow-up: median 6 months)												
1 [170, 174]	randomized trials	not serious[a]	not serious	serious[b,c]	serious[d]	none	4/3461 (0.1%)	4/1736 (0.2%)	**RR 0.50** (.13 to 2.00)	**1 fewer per 1000** (from 2 fewer to 2 more)	⊕⊕◯◯ LOW	CRITICAL
Symptomatic COVID-19 (follow-up: median 6 months; assessed with: RT-PCR–positive symptomatic illness)												
1 [170, 174]	randomized trials	not serious	not serious	serious[c]	serious[d]	none	11/3441 (0.3%)	31/1731 (1.8%)	**HR 0.17** (.08 to .33)	**15 fewer per 1000** (from 16 fewer to 12 fewer)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: median 83 days)												
1 [170, 174]	randomized trials	not serious	not serious	serious[c]	serious[d]	none	50/3461 (1.4%)	23/1736 (1.3%)	**RR 1.09** (.67 to 1.78)	**1 more per 1000** (from 4 fewer to 10 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; RR, risk ratio; RT-PCR, reverse transcriptase–polymerase chain reaction.

[a]Possible misclassification bias due to unequal rate of dropouts after unblinding.

[b]Two deaths in the control arm were attributed to COVID-19.

[c]Trial population indirect to the population indicated within the FDA EUA (eg, immunocompromised).

[d]Small number of events; fragility present.

Table 22. GRADE Evidence Profile, Recommendation 21—Question: Prophylactic Casirivimab/Imdevimab Compared to No Prophylactic Casirivimab/Imdevimab for Persons Exposed to COVID-19 at High Risk for Progression to Severe Disease (*Developed 17 August 2021; Last Reviewed 19 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Prophylactic Casirivimab /Imdevimab	No Prophylactic Casirivimab/ Imdevimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Symptomatic SARS-CoV-2 infection (1200 mg sc) (follow-up: 28 days; assessed with: RT-qPCR plus broad-term definition)												
1 [175]	randomized trials	not serious	not serious	not serious	serious[a]	none	11/753 (1.5%)	59/752 (7.8%)	**RR 0.19** (.10 to .35)	**64 fewer per 1000** (from 71 fewer to 51 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Duration of symptomatic infection (1200 mg sc)												
1 [175]	randomized trials	not serious	not serious	not serious	very serious[a]	none	11	59	…	**Mean Difference of 2 weeks fewer** (2.91 fewer to 1.09 fewer)	⊕⊕◯◯ LOW	CRITICAL
COVID-19–related hospitalizations or ER visits (1200 mg sc) (follow-up: 28 days)												
1 [175]	randomized trials	not serious	not serious	not serious[b]	very serious[a,c]	none	0/753 (0.0%)	4/752 (0.5%)	**RR 0.11** (.01 to 2.06)	**5 fewer per 1000** (from 5 fewer to 6 more)	⊕⊕◯◯ LOW	CRITICAL
Serious treatment-emergent adverse events (1200 mg sc) (follow-up: 28 days)												
1 [175]	randomized trials	not serious	not serious	serious[d]	serious[a,c]	none	10/1311 (0.8%)	15/1306 (1.1%)	**RR 0.66** (.30 to 1.47)	**4 fewer per 1000** (from 8 fewer to 5 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; MD, mean difference; RR, risk ratio; RT-qPCR, reverse transcriptase–quantitative polymerase chain reaction; sc, subcutaneously.

[a]Small number of events; fragility present.

[b]COVID-19–related hospitalizations is a surrogate for ICU admission, mechanical ventilation, and death. Not rated down.

[c]95% CI cannot exclude meaningful harm.

[d]Serious treatment-emergent adverse events reported for entire study population (including symptomatic and asymptomatic) and may not be generalizable to seronegative population.

The following medical conditions or other factors may place adults and pediatric patients (age 12-17 years and weighing at least 40 kg) at higher risk for progression to severe COVID-19:

- Older age (for example ≥65 years of age)
- Obesity or being overweight (for example, adults with BMI >25 kg/m², or if age 12-17, have BMI ≥85th percentile for their age and gender based on CDC growth charts
- Pregnancy
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension
- Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate to severe], interstitial lung disease, cystic fibrosis and pulmonary hypertension)
- Sickle cell disease
- Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation [not related to COVID-19])

Figure 4. Risk factors for the progression to severe COVID-19 or hospitalization per FDA EUA [176–178]. These criteria refer to recommendation 22. Abbreviations: BMI, body mass index; CDC, Centers for Disease Control and Prevention; COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration.

large number of potentially eligible individuals and supply constraints.

Casirivimab/Imdevimab. The panel agreed that the overall CoE for PEP with casirivimab/imdevimab was low due to the low number of events (fragility of results). The panel notes some indirectness between the trial participants (30.5% with any high-risk factor for COVID) and the current approved indications for PEP within the EUA.

Conclusions and Research Needs for This Recommendation

Tixagevimab/Cilgavimab. The guideline panel suggests PrEP with tixagevimab/cilgavimab in moderately or severely immunocompromised individuals at increased risk for inadequate immune response to COVID-19 vaccine or for whom COVID-19 vaccine is not recommended due to documented severe reactions to the COVID-19 vaccine. Data on the efficacy of PrEP specifically in immunocompromised individuals who have received COVID-19 vaccines are needed.

Casirivimab/Imdevimab. The guideline panel suggests against postexposure casirivimab/imdevimab unless predominant regional variants are susceptible to the agent.

Neutralizing Antibodies for Treatment

Section last reviewed and updated 23 May 2022

Last literature search conducted 30 April 2022

Resources:

- CDC: SARS-CoV-2 variants.
- FDA: Qualifications for SARS-CoV-2 exposure.

Recommendation 22: Among ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel suggests treatment with anti–SARS-CoV-2 monoclonal antibodies with activity against the predominant regional variants* within 7 days of symptom onset rather than no anti–SARS-CoV-2 monoclonal antibodies. (conditional recommendation†, moderate certainty of evidence)**

Remarks:

- The evolving nature of variants may necessitate recommendations based on clinical data accrued using agents that are no longer effective against the predominant circulating variants, combined with in vitro data for newer agents.
- Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital for reasons other than COVID-19 may also receive treatment with anti–SARS-CoV-2 monoclonal antibodies with activity against the predominant regional variant.

- Although bebtelovimab has shown in vitro activity against Omicron subvariant BA.2, in contrast with previous monoclonal antibodies, clinical safety and efficacy data are sparse with no comparative data in high-risk patients, limiting use to patients who are not candidates for alternative treatments. Patients who place a higher value on greater certainty of benefit may reasonably decline bebtelovimab (Figure 4).

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

**For current information on circulating SARS-CoV-2 variants in the United States, please visit the CDC website.*

***For in vitro susceptibility information for SARS-CoV-2 variants, please visit Stanford University's Coronavirus Antiviral & Resistance Database.*

Why Are Neutralizing Antibodies Considered for Treatment?

Neutralizing antibodies directed at the receptor-binding domain of SARS-CoV-2 spike protein have been evaluated as therapeutic agents for COVID-19. In animal models there is evidence that antibody therapy may more rapidly reduce viral load in the upper and lower airways of infected animals, resulting in reduced virus-induced pathology [171, 172]. Additionally, antibody-mediated enhancement of disease, a theoretical adverse effect of neutralizing antibody therapy, has not been detected in animal models or in clinical studies [172].

Potential advantages of neutralizing antibodies include the ability to standardize the amount of neutralizing activity and the possibility of conferring protection more rapidly than with vaccine-induced immune responses (which generally take several weeks).

As the pandemic has progressed, new SARS-CoV-2 variants have emerged with reduced neutralizing susceptibility to various anti–SARS-CoV2 monoclonal antibodies in assays performed using infectious (also referred to as authentic) and pseudotyped viruses. For example, the first 2 authorized monoclonal antibody combinations, bamlanivimab/etesevimab and casirivimab/imdevimab, have been found to be largely inactive against the Omicron BA.1 and BA.2 variants. As a result, the FDA limited use of these products only to geographic regions where susceptible variants are likely, of which there are none remaining in the United States.

In a meta-analysis published as a preprint, sotrovimab displayed a median 4.0-fold (IQR: 2.6–6.9-fold) reduction in activity against Omicron BA.1 in 34 studies and a median 17-fold (IQR: 13–30-fold) reduction in activity against Omicron BA.2 in 12 studies [179]. In this same meta-analysis, the combination of cilgavimab/tixagevimab displayed a median 86-fold (IQR: 27–151-fold) reduction in activity against Omicron BA.1 in 15 studies and a median 5.4-fold (IQR: 3.7–6.9-fold) reduction in activity against Omicron BA.2 in 6 studies. In 8 studies assessing activity against Omicron BA.1 and 6 studies against Omicron BA.2, bebtelovimab displayed no reduction in activity.

As a result of the high proportion of cases in the United States arising from Omicron BA.2, the FDA discontinued the authorization of sotrovimab for treating SARS-CoV-2 infections on 5 April 2022. Despite limited clinical efficacy data, bebtelovimab was authorized for outpatient treatment of high-risk patients with COVID-19 primarily based on its in vitro activity.

Summary of the Evidence

Our search identified 6 publications of 5 RCTs reporting on treatment with neutralizing antibodies (bamlanivimab, combination of casirivimab/imdevimab, combination of bamlanivimab/etesevimab, or sotrovimab) for patients with COVID-19 [180–185] (Tables 23–25). Due to clinical heterogeneity of the outcome measures across studies, meta-analyses combining the different neutralizing antibodies were not considered appropriate.

One RCT, stopped early for futility, reported on hospitalized patients with COVID-19 randomized to treatment with either a single infusion of bamlanivimab (7000 mg) or placebo (ACTIV-3/TICO) [181]. One phase II/III RCT reported on nonhospitalized patients (adults as well as children aged ≥12 years) considered at high risk for progression to severe disease who were within 3 days of their first positive test for SARS-CoV-2 and were randomized to a single infusion of bamlanivimab 2800 mg/etesevimab 2800 mg or placebo [182]. One phase II RCT reported on nonhospitalized patients with recently diagnosed mild or moderate COVID-19 randomized to treatment with either a single infusion of neutralizing antibody bamlanivimab in 1 of 3 doses (700 mg, 2800 mg, or 7000 mg) or placebo [180].

One phase III RCT assessed a single infusion of either 1200 mg or 2400 mg casirivimab/imdevimab in nonhospitalized participants with mild-to-moderate COVID-19 [184]. In the original phase of this trial, participants without risk factors for severe disease were included; however, 1040 participants were removed after randomization and not analyzed as they had no risk factors for severe disease. In the amended phase of this investigation, all participants were considered at high risk for severe disease. Another phase III RCT also reported on nonhospitalized participants with mild-to-moderate COVID-19 who were at risk for severe disease [183]. Participants in this study received a single infusion of sotrovimab 500 mg. Unlike previous studies, this study did exclude participants with immunocompromising conditions.

Table 23. GRADE Evidence Profile, Recommendation 22—Question: Bamlanivimab/Etesevimab Compared to No Bamlanivimab/Etesevimab for Ambulatory Persons With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Updated 2 March 2021; Last Reviewed 19 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Bamlanivimab/ Etesevimab	No Bamlanivimab/ Etesevimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 29 days)												
1 [182]	randomized trials	not serious	not serious	not serious[a]	serious[b]	none	0/518 (0.0%)	10/517 (1.9%)	**RR 0.05** (.00 to 0.80)[c]	**19 fewer per 1000** (from 31 fewer to 7 fewer)[d]	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalization (≥24 hours of acute care) with COVID-19 (follow-up: 29 days)												
1 [182]	randomized trials	not serious	not serious	not serious[a,e]	serious[b]	none	11/518 (2.1%)	36/517 (7.0%)	**RR 0.30** (.16 to .59)	**49 fewer per 1000** (from 58 fewer to 29 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Persistently high viral load at day 7 (follow-up: 7 days; assessed with: RT-PCR)												
1 [182]	randomized trials	not serious	not serious	serious[a,f]	serious[b]	none	50/508 (9.8%)	145/499 (29.1%)	**RR 0.34** (.25 to .46)	**192 fewer per 1000** (from 218 fewer to 157 fewer)	⊕⊕◯◯ LOW	IMPORTANT
Serious adverse events												
1 [182]	randomized trials	not serious	not serious	not serious[a]	serious[b]	none	7/518 (1.4%)	5/517 (1.0%)	**RR 1.40** (.45 to 4.37)	**4 more per 1000** (from 5 fewer to 33 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RR, risk ratio; RT-PCR, reverse transcriptase–polymerase chain reaction.

[a]Estimate reflects the use of a higher dose than treatment dose approved by the FDA.

[b]Fragility present, low number of events.

[c]RR estimated by using continuity correction of 0.5.

[d]As the RR 95% CI is wide due to sparse data, absolute risk difference recalculated independently and not based on RR.

[e]Hospital admission is an intermediary outcome for morbidity, ICU admission, and need for ventilation. Not rated down.

[f]Measure of viral clearance is a surrogate outcome for hospital admission, need for intensive care, intubation, and death.

Table 24. GRADE Evidence Profile, Recommendation 22—Question: Casirivimab/Imdevimab Compared to No Casirivimab/Imdevimab for Ambulatory Persons With Mild-to-Moderate COVID-19 at High Risk of Progression to Severe Disease (*Last Updated 16 June 2021; Last Reviewed 19 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Casirivimab/ Imdevimab	No Casirivimab/ Imdevimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
All-cause mortality (1200 mg) (follow-up: 29 days)												
1 [184]	randomized trials	not serious[a]	not serious	not serious	very serious[b,c]	none	1/736 (0.1%)	1/748 (0.1%)	**RR 1.02** (.06 to 16.20)	**0 fewer per 1000** (from 4 fewer to 4 more)[d]	⊕⊕◯◯ LOW	CRITICAL
COVID-19 related hospitalizations (1200 mg) (follow-up: 29 days)												
1 [184]	randomized trials	not serious[a]	not serious	not serious[e]	serious[b]	none	6/736 (0.8%)	23/748 (3.1%)	**RR 0.27** (.11 to .65)	**22 fewer per 1000** (from 27 fewer to 11 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events (all doses) (follow-up: 29 days)												
1 [184]	randomized trials	not serious[a]	not serious	not serious	serious[b]	none	50/3688 (1.4%)	74/1843 (4.0%)	**RR 0.34** (.24 to 0.48)	**27 fewer per 1000** (from 31 fewer to 21 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RR, risk ratio.

[a]Differential post-randomization event exclusions (1040 participants) in the original phase (participants without risk factors) are unknown. Publication did not provide an intention-to-treat analysis. Not rated down for risk of bias as the data in this evidence profile are limited to the amended phase 1200-mg dose only and not the entire dataset (1200 mg is the currently recommended dose). However, sensitivity analysis of the entire dataset showed similar results: for hospitalizations 23/2091 vs 59/1341 (RR: 0.25; 95% CI: .16, .4); deaths: 2/2091 vs 3/1341 (RR: 0.43; 95% CI: .08, 2.3).

[b]Small number of events; fragility present.

[c]95% CI cannot exclude no difference or increased mortality.

[d]As the RR 95% CI is wide due to sparse data, absolute risk difference recalculated independently and not based on RR.

[e]COVID-19–related hospitalizations is a surrogate for ICU admission, mechanical ventilation, and death. Not rated down.

Table 25. GRADE Evidence Profile, Recommendation 22—Question: Sotrovimab Compared to No Sotrovimab for Ambulatory Persons With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 17 May 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Sotrovimab	No Sotrovimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 29 days)												
1 [183]	randomized trials	not serious	not serious	not serious	serious[a]	none	0/528 (0.0%)	2/529 (0.4%)	**RR 0.20** (.01 to 4.16)[b]	**4 fewer per 1000** (from 9 fewer to 1 more)[c]	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalization (>24 hours for any cause) (follow-up: 29 days)												
1 [183]	randomized trials	not serious	not serious	not serious[d]	serious[a]	none	6/528 (1.1%)	29/529 (5.5%)	**RR 0.21** (.09 to .50)	**43 fewer per 1000** (from 50 fewer to 27 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Progression to severe or critical disease (follow-up: 29 days)												
1 [183]	randomized trials	not serious	not serious	not serious[d]	serious[a]	none	7/528 (1.3%)	28/529 (5.3%)	**RR 0.25** (.11 to .57)	**40 fewer per 1000** (from 47 fewer to 23 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events (follow-up: 29 days)												
1 [183]	randomized trials	not serious	not serious	not serious	serious[a]	none	11/523 (2.1%)	32/526 (6.1%)	**RR 0.35** (.18 to .68)	**40 fewer per 1000** (from 50 fewer to 19 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RR, risk ratio.

[a]Small number of events; fragility present.

[b]RR estimated by using continuity correction of 0.5.

[c]As the RR 95% CI is wide due to sparse data, absolute risk difference recalculated independently and not based on RR.

[d]COVID-19–related hospitalizations is a surrogate for ICU admission, mechanical ventilation, and death. Not rated down for indirectness.

Additional clinical data from the PYAH/BLAZE-4 trials were obtained from the manufacturer's fact sheet supporting the EUA for bebtelovimab. Treatment arms 9 through 11 compared bebtelovimab alone with placebo in patients at low risk for COVID-19. Although an additional arm included patients at high risk for progression to severe COVID-19, bebtelovimab was not studied against placebo but rather against combination neutralizing antibodies, precluding estimates of effectiveness against usual care in this population [186].

Benefits

Bamlanivimab/Etesevimab. [***NOTE:*** *On 24 January 2022, FDA limited EUA for bamlanivimab/etesevimab to patients likely to have been infected with or exposed to a variant that is susceptible to this treatment. At present (19 May 2022), nowhere in the United States meets this criterion, and the drug is not available.*] [187]

In ambulatory persons at high risk for severe COVID-19, bamlanivimab/etesevimab demonstrated an absolute mortality reduction of 1.9% (95% CI includes a minimum of .7% reduction in mortality) as no deaths were seen by day 29 in the 518 persons treated with bamlanivimab/etesevimab compared with 10 deaths in the 517 persons who received placebo. However, due to the small number of events (10, of which 9 were believed to the result of COVID-19), the CoE was low due to imprecision. Bamlanivimab/etesevimab demonstrated a lower relative risk of COVID-19–related hospitalizations (defined as ≥24 hours of acute care) through day 29 compared with no bamlanivimab/etesevimab (RR: .30; 95% CI: .16, .59; low CoE). Ambulatory persons who received bamlanivimab/etesevimab had a lower relative risk of persistently high viral load at day 7 compared with no bamlanivimab/etesevimab (RR: .34; 95% CI: .25, .46; low CoE).

Casirivimab/Imdevimab. [***NOTE:*** *On 24 January 2022, FDA limited EUA for casirivimab/imdevimab to patients likely to have been infected with or exposed to a variant that is susceptible to this treatment. At present (19 May 2022), nowhere in the United States meets this criterion, and the drug is not available.*] [187]

Concerns were raised by the panel whether bias could have been introduced by excluding 1040 persons post-randomization (2400-mg dose group) due to lack of risk factors for severe disease. Therefore, the panel used the amended phase (1200-mg dose) full dataset to inform the effect estimates as no exclusions were reported. Sensitivity analyses were carried out to test the robustness of this approach by either adding the 2400-mg to the 1200-mg dose dataset or by formally pooling both effect estimates using fixed-effects model; these sensitivity analyses resulted in little to no relevant differences in the findings. In addition, the amended phase lower dose (1200 mg) results also served as confirmation that the latest EUA recommended dosing appears to be equally effective as the previously authorized higher dose.

Among ambulatory persons with at least 1 risk factor for severe disease, there was no difference in 29-day mortality in persons treated with casirivimab/imdevimab compared with no casirivimab/imdevimab 1200 mg (RR: 1.02; 95% CI: .06, 16.20; low CoE). However, there was a lower relative risk of hospitalization in persons treated with casirivimab/imdevimab 1200 mg (RR: .27; 95% CI: .11, .65; moderate CoE).

Sotrovimab. [***NOTE****: On 5 April 2022, sotrovimab is no longer authorized to treat COVID-19 in any US region due to increases in the proportion of COVID-19 cases caused by the Omicron BA.2 subvariant.*] [188]

Among ambulatory persons with at least 1 risk factor for severe disease, sotrovimab demonstrated a lower relative risk of mortality compared with no sotrovimab (RR: .20; 95% CI: .01, 4.16, low CoE). The moderate CoE was due to imprecision as there were no mortality events in those who received sotrovimab and 2 deaths in the placebo arm. Among ambulatory persons, sotrovimab use was associated with a lower relative risk of hospitalization compared with no sotrovimab (RR: .21; 95% CI: .09, .50; moderate CoE). Persons receiving sotrovimab had a lower progression to severe or critical disease compared with no sotrovimab (RR: .25; 95% CI: .11, .57; moderate CoE).

Bebtelovimab Monotherapy. Among ambulatory persons, the limited data available for bebtelovimab failed to show or to exclude a beneficial effect on hospitalizations (RR: 1.02; 95% CI: .15, 7.16; very low CoE). The very low certainty was due to extremely serious imprecision as only 2 events occurred in each study arm, making the estimate uninformative. No deaths were reported, likely due to a combination of the low-risk population and small sample size. The panel did not consider additional outcomes such as persistently high viral load by day 7 (no significant difference) or time to sustained symptom resolution (6 vs 8 days in placebo), as the clinical relevance of those outcomes remained uncertain and judged as not critical for decision making.

Bamlanivimab Monotherapy. [***NOTE****: On 16 April 2021, FDA revoked EUA for monoclonal antibody bamlanivimab.*] [189]

Among ambulatory persons, bamlanivimab demonstrated a lower relative risk of hospitalization, including visits to the emergency room, compared with no bamlanivimab (RR: .26; 95% CI: .09, .75; very low CoE). The very low CoE was due to indirectness, as the treatment may not have been provided to enough persons at risk of developing severe disease to be representative of the general population, and imprecision, due to few events recorded. Bamlanivimab may increase viral clearance at 3 days (MD: −.49; 95% CI: −.87, −.11; low CoE); however, there may not be a meaningful difference at 11 days as

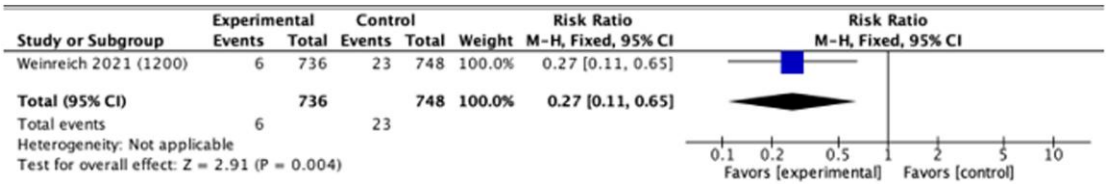

Figure 5. Forest plot for the outcome of hospitalizations for casirivimab/imdevimab versus no casirivimab/etesevimab (data for 1200-mg dose only) [184]. Abbreviation: CI, confidence interval.

measured by change from baseline SARS-CoV-2 viral load (MD: −.22; 95% CI: −.60, .15; low CoE).

Among patients hospitalized for COVID-19, treatment with bamlanivimab compared with placebo failed to show or exclude a beneficial effect on mortality (HR: 2.00; 95% CI: .67, 5.99; moderate CoE). Clinical improvement, as defined as a decrease in a pulmonary ordinal scale, may not be meaningfully different among patients hospitalized for COVID-19 who received treatment with bamlanivimab or placebo (OR: .85; 95% CI: .56, 1.29; moderate CoE).

Harms

Bamlanivimab/Etesevimab. Persons receiving bamlanivimab/etesevimab experienced more serious adverse events. However, this may not be meaningfully different from those receiving placebo (RR: 1.40; 95% CI: .45, 4.37; moderate CoE).

Casirivimab/Imdevimab. Serious adverse events were less frequent among persons receiving casirivimab/imdevimab compared with those receiving placebo (RR: .34; 95% CI: .24, .48; moderate CoE).

Sotrovimab. Persons who received sotrovimab were less likely to experience serious adverse events compared with those receiving placebo (RR: .35; 95% CI: .18, .68; moderate CoE).

Bebtelovimab Monotherapy. Three serious adverse events were reported for bebtelovimab compared with zero in the control group, but due to the small sample size this estimate remains uncertain (RR: 3.41; 95% CI: .17, 67.50; very low CoE).

Bamlanivimab Monotherapy. Serious adverse events among ambulatory persons receiving bamlanivimab monotherapy may not be meaningfully different from those receiving placebo (RR: .15; 95% CI: .01, 3.78; low CoE). Persons receiving bamlanivimab did experience more infusion-related adverse events, including pruritus, flushing, rash, and facial swelling (RR: 1.62; 95% CI: .34, 7.70; low CoE).

Similarly, serious adverse events at 5 and 28 days among patients hospitalized for COVID-19 receiving bamlanivimab may not be meaningfully different from those receiving placebo (RR: 1.85; 95% CI: .34, 9.97 [moderate CoE]; and RR: .93, 95% CI: .27, 3.14 [moderate CoE], respectively). Similarly, infusion-related adverse events may not be meaningfully different between patients hospitalized for COVID-19 receiving bamlanivimab or placebo (OR: 1.64, 95% CI: .79, 3.44; moderate CoE).

Other Considerations

Neutralizing Antibodies for Ambulatory Persons. The panel agreed that the overall CoE for the treatment with bamlanivimab/etesevimab, casirivimab/imdevimab, and sotrovimab in ambulatory persons with COVID-19 at high risk for progression to severe disease (at least 1 risk factor) was moderate due to the mostly low number of events (fragility of results). The results were driven by the number of avoided hospitalizations, as the number of deaths that occurred were too sparse to show a clear trend. Neutralizing antibodies were well tolerated, and serious adverse events were comparable or lower than placebo. The panel noted increased feasibility with the option of providing treatment with casirivimab/imdevimab through subcutaneous injections [175, 190].

Casirivimab/imdevimab has been evaluated for the treatment of COVID-19 at doses of 1200 mg, 2400 mg, and 8000 mg. Across all treatment doses, there was a flat dose–response relationship for viral load and clinical outcomes. As part of the FDA EUA, the use of casirivimab/imdevimab as an IV infusion is strongly recommended; however, the subcutaneous route is authorized as an alternate route when IV infusion is not feasible and would result in a delay in treatment. Clinical outcomes of patients receiving casirivimab/imdevimab via the subcutaneous route for the treatment of COVID-19 have not been reported in available trials. A manuscript [190] evaluated early casirivimab/imdevimab 1200 mg versus placebo in asymptomatic outpatients with COVID-19 and demonstrated fewer hospitalizations in those receiving casirivimab/imdevimab compared with those receiving placebo: 0/100 versus 3/104, respectively (RR: .15; 95% CI: .01, 2.84). Peak pharmacokinetic levels in those receiving subcutaneous casirivimab 600 mg/imdevimab 600 mg appear approximately 75% lower than after IV infusion [191].

Bebtelovimab Monotherapy. The panel agreed that, due to the extremely limited clinical data for bebtelovimab, the CoE was

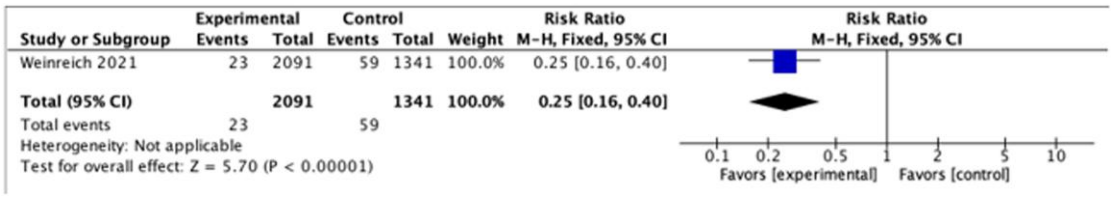

Figure 6. Forest plot for the outcome of hospitalizations for casirivimab/imdevimab versus no casirivimab/etesevimab (combining data for 2400-mg dose and 1200-mg dose) [184]. Abbreviation: CI, confidence interval.

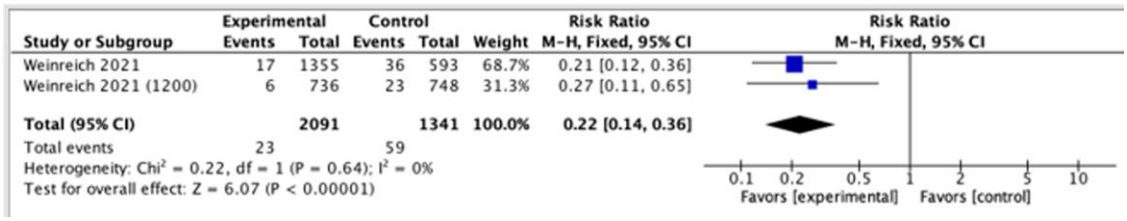

Figure 7. Forest plot for the outcome of hospitalizations for casirivimab/imdevimab versus no casirivimab/etesevimab (pooling data for 2400-mg dose and 1200-mg dose) [184]. Abbreviation: CI, confidence interval.

very low, making any estimate of beneficial or harmful effect uninformative.

Bamlanivimab Monotherapy. The panel agreed that the overall CoE for treatment with bamlanivimab for ambulatory persons with COVID-19 is very low due to concerns with indirectness and imprecision.

The panel agreed that the overall CoE for treatment with bamlanivimab for patients hospitalized for COVID-19 is moderate due to concerns with fragility in the estimate from the small number of events reported. The guideline panel made a strong recommendation against treatment with bamlanivimab for patients hospitalized for COVID-19. The panel was moderately certain that any relevant benefit (reduction in mortality or clinical improvement) could be excluded.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests treatment with anti–SARS-CoV-2 monoclonal antibodies with activity against the predominant regional variants within 7 days of symptom onset in ambulatory persons with mild-to-moderate COVID-19 at high risk for developing severe disease as the expected benefits likely outweigh any potential harms when given in patients infected with susceptible variants (Tables 23–25). Although bebtelovimab has shown in vitro activity against Omicron subvariant BA.2, in contrast with previous monoclonal antibodies, clinical safety and efficacy data are sparse, with no comparative data in high-risk patients, limiting its use to patients who are not candidates for alternative treatments (Figures 5–7).

Currently, no anti–SARS-CoV-2 monoclonal antibodies studied in clinical trials among hospitalized patients with COVID-19 show in vitro activity against predominant regional variants (Tables 26–28).

The guideline panel recognized the need for continued research and accrual of evidence, particularly trials on patient-important outcomes (hospitalizations progressing to need for ventilation, or death), existing and new neutralizing antibodies, and outcomes with variants of concern (Supplementary Table 2).

Janus Kinase Inhibitors: Baricitinib

Section last reviewed and updated 29 April 2022

Last literature search conducted 31 March 2022

Recommendation 23: Among hospitalized adults with severe* COVID-19, the IDSA panel suggests baricitinib with corticosteroids rather than no baricitinib. (conditional recommendation†, moderate certainty of evidence)

Remarks:

- Baricitinib 4 mg per day (or appropriate renal dosing) up to 14 days or until discharge from hospital.
- Baricitinib appears to demonstrate the most benefit in those with severe COVID-19 on high-flow oxygen/noninvasive ventilation at baseline.
- Limited additional data suggest a mortality reduction even among patients requiring mechanical ventilation.

Recommendation 24: Among hospitalized patients with severe* COVID-19 who cannot receive a corticosteroid (which is standard of care) because of a contraindication, the IDSA guideline panel suggests use of baricitinib with remdesivir rather than remdesivir alone. (conditional recommendation†, low certainty of evidence)

- **Remark:** Baricitinib 4 mg per day for 14 days or until hospital discharge. The benefits of baricitinib plus remdesivir for persons on mechanical ventilation are uncertain.

Severity definitions:

**Severe illness is defined as patients with SpO_2 ≤94% on room air, including patients on supplemental oxygen, oxygen through a high-flow device, or noninvasive ventilation.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Baricitinib Considered for Treatment?

Baricitinib, a selective Janus kinase 1 and 2 (JAK1 and JAK2, respectively) inhibitor currently FDA-approved for the treatment of RA, is being investigated in multiple studies for treatment of COVID-19. The proposed benefits of baricitinib in the management of COVID-19 may be 2-fold as it has both anti-inflammatory and potential antiviral activity [193]. Janus kinase (JAK) mediates cytokine signaling, which contributes to inflammation; JAK inhibitors, therefore, may decrease cytokine-mediated inflammation. Baricitinib inhibits host intracellular membrane proteins AP2-associated protein kinase 1 (AAK1) and also binds cyclin G-associated kinase (GAK), both thought to play a role in receptor-mediated endocytosis of many viruses including Ebola, dengue, hepatitis C, and SARS-CoV-2 [194–196]. Baricitinib has been evaluated in people with COVID-19 in both randomized and nonrandomized studies [197–201].

Based on experience in clinical trials for RA, baricitinib has been associated with an increased risk of adverse effects, including infections (especially upper respiratory tract infections), thrombosis, lymphopenia, anemia, increases in lipids, elevations in liver enzymes, and elevations in creatinine phosphokinase [193]. In clinical trials for RA, baricitinib was associated with a numerically higher risk of upper respiratory tract infections and herpes simplex and herpes zoster infections compared with placebo [202]. Opportunistic infections such as herpes simplex, herpes zoster, and tuberculosis [203, 204] have been reported in patients taking baricitinib. Many of these side effects appear to be dose related, with increased incidence in patients taking baricitinib 4 mg compared with 2 mg. Patients enrolled in the Adaptive COVID-19 Treatment Trial (ACTT-2), COV-BARRIER, and RECOVERY trial received baricitinib 4 mg daily for 2–14 days or until discharge, a shorter duration than those taking the drug for RA.

Patients with COVID-19 have been found to have abnormalities in coagulation parameters and might have an elevated risk of thrombosis [205]. Baricitinib receipt was associated with an increased incidence of thrombosis when compared with placebo receipt in clinical trials for its FDA approval for RA, especially at a higher dose of 4 mg daily [193]. During the 16-week treatment period in RA trials, venous thromboembolism (VTE) occurred in 5 patients treated with baricitinib 4 mg daily, compared with zero in the 2-mg-daily and placebo groups. Arterial thrombosis occurred in 2patients treated with baricitinib 4 mg, 2 patients treated with baricitinib 2 mg, and 1 patient on placebo. In ACTT-2, the percentage of patients reported to have VTE was numerically higher in the combination group (21 patients [4.1%] vs 16 patients [3.1%]), although it was similar overall (absolute difference: 1%; 95% CI: −1.3%, 3.3%) [206]. Of note, all patients in ACTT-2 were recommended to receive VTE prophylaxis if they had no contraindication. We do not have long-term data, especially on safety, development of the aforementioned adverse effects, and opportunistic infections from these 2 trials (Tables 29 and 30).

Summary of the Evidence

Baricitinib. Our literature search identified 2 RCTs that compared the use of baricitinib (4 mg daily dose up to 14 days) with placebo in hospitalized adults. One trial, COV-BARRIER, included patients with severe COVID (National Institute of Allergy and Infectious Diseases [NIAID] ordinal scale [OS]: 4—hospitalized, not requiring supplemental oxygen; 5—hospitalized, requiring supplemental oxygen; or 6—hospitalized, receiving noninvasive ventilation or high-flow oxygen devices) [201, 207, 208]. Critically ill and mechanically ventilated patients (OS7) were excluded from COV-BARRIER study. In the COV-BARRIER trial, randomization was stratified by disease severity, age, region, and use of corticosteroids. Participants in both arms had 1 or more elevated inflammatory marker (CRP, d-dimer, lactate dehydrogenase, ferritin) and also received standard of care, which included corticosteroids in 79% and/or antivirals (eg, remdesivir in 18.9%). The RECOVERY trial included patients hospitalized for COVID-19. Approximately, 70% of patients received supplemental oxygen, 25% received non-invasive ventilation, and 3% received invasive ventilation. Participants in both arms received standard of care, which included corticosteroids in approximately 95% and/or antivirals (eg, remdesivir in 20%).

An additional exploratory trial subsequent to the COV-BARRIER primary trial of baricitinib treatment for critically ill (OS7) patients with COVID-19 pneumonia requiring invasive mechanical ventilation was identified that reported

on the outcomes of mortality, need for invasive mechanical ventilation, days of hospitalization, and serious adverse events [209].

Baricitinib Without Corticosteroids, With Remdesivir. Our literature search identified 1 RCT that reported on the use of baricitinib (4-mg daily dose) plus remdesivir in hospitalized patients with moderate and severe COVID-19 [206]. This trial was conducted as the second stage of the ACTT-2, where subjects were randomized to receive combination therapy with baricitinib and remdesivir or remdesivir alone [206] (Table 31). Randomization was stratified by disease severity classified by an OS of clinical status (4 + 5 vs 6 + 7). Patients in ordinal scale 6 were on high-flow oxygen and non-invasive ventilation and those in ordinal scale 7 were on mechanical ventilation or ECMO. Patients in ordinal scale 4 were hospitalized, but not requiring supplemental oxygen and those in ordinal scale 5 were hospitalized and requiring supplemental oxygen. The trial was initiated before corticosteroids were commonly used for severe COVID-19.

Benefits

Baricitinib. Treatment of hospitalized patients with severe COVID-19 with baricitinib rather than no baricitinib reduced 60-day mortality (RR: .87; 95% CI: .78, .96; moderate CoE). The odds of COVID-19 disease progression trends toward a reduction in persons receiving treatment with baricitinib (OR: .85; 95% CI: .67, 1.08; moderate CoE), as well as the risk of needing mechanical ventilation (RR: .85; 95% CI: .73, .99; moderate CoE).

Treatment of critically ill hospitalized patients with baricitinib rather than no baricitinib reduced the risk of 60-day mortality (RR: .74; 95% CI: .57, .97; moderate CoE).

Baricitinib Without Corticosteroids, With Remdesivir. In ACTT-2, the combination of baricitinib and remdesivir showed a trend towards lower mortality (4.7% vs 7.1%; rate ratio: .65; 95% CI: .39, 1.09; moderate CoE). In patients stratified within the severe COVID-19 pneumonia group, defined as 6 or 7 on the ordinal scale, subjects who received baricitinib and remdesivir were more likely to experience clinical recovery (defined as a value of <4 on the ordinal scale) at day 28 (69.3% vs 59.7%; rate ratio: 1.29; 95% CI: 1.00, 1.66; moderate CoE). The original stratification was altered as 40 subjects were misclassified at baseline; however, re-analysis of the original stratified data produced a similar result. Patients in the baricitinib arm were less likely to require initiation of mechanical ventilation or ECMO through day 29 (10% vs 15.2%; RR: .66; 95% CI: .46, .93; low CoE). In summary, it appeared that patients requiring supplemental oxygen or noninvasive ventilation at baseline benefitted most from baricitinib; the benefit was less clear in patients already on mechanical ventilation.

Harms

The risk of serious adverse events in hospitalized patients with severe or critical COVID-19 receiving baricitinib was not greater than those not receiving baricitinib (RR: .82; 95% CI: .65, 1.03 [moderate CoE]; and RR: .70; 95% CI: .50, .97 [moderate CoE], respectively). Patients who were immunocompromised (ie, received immunosuppressant drugs or were neutropenic) and had a history of recent of thromboembolism were not excluded from the RECOVERY trial, unlike the BARRIER-COV trial. Noncomparative serious adverse events were reported in the RECOVERY 2022 trial (baricitinib n = 4148): 13 total (5 serious infections; 3 bowel perforations; 2 pulmonary embolisms; and 1 each of ischemic colitis, elevated transaminases, and seizure).

In ACTT-2, patients receiving baricitinib and remdesivir had a lower risk of developing any serious adverse events through day 28 (16% vs 21%; RR: .76; 95% CI: .59, .99; moderate CoE) whether or not thought to be related to the study drug. In this trial, the overall rate of new infections was lower in the baricitinib plus remdesivir group compared with remdesivir alone (30 patients [5.9%] vs 57 patients [11.2%]) [206]. However, patients who received concomitant glucocorticoids had a higher incidence of serious or nonserious infections as compared with those who did not: 25.1% and 5.5%, respectively. It was not specified what proportion of these patients in the study were in the baricitinib combination group versus the control group.

Other Considerations

Baricitinib. The panel agreed on the overall CoE as moderate due to concerns with imprecision, as some outcomes have concerns with fragility. The guideline panel recognized the resource implications based on the dose and duration reported in the trial (4 mg daily up to 14 days). Additional data from hospitalized patients with critical COVID-19 suggest consistent benefits; however, there are concerns with imprecision based on a small sample in this group.

Baricitinib Without Corticosteroids. The panel agreed that the overall CoE was low due to concerns with risk of bias, driven by the use of data from post hoc analyses and imprecision, which recognized the limited events and concerns with fragility in the group who likely benefited most (those requiring supplemental oxygen or noninvasive ventilation). The guideline panel noted the importance of suggesting baricitinib plus remdesivir as an option for persons unable to receive corticosteroids.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests baricitinib in addition to standard of care for patients hospitalized with severe COVID-19. The guideline panel suggests baricitinib with remdesivir for persons for whom corticosteroids are indicated but who cannot receive them due to a contraindication. Baricitinib plus remdesivir

Table 26. GRADE Evidence Profile—Question: Bebtelovimab Compared to No Bebtelovimab for Ambulatory Patients With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 3 March 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Bebtelovimab	No Bebtelovimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 29 days)												
1 [186]	randomized trials	not serious	not serious	not serious	extremely serious[a]	none	0/125 (0.0%)	0/128 (0.0%)	not estimable	…	⊕◯◯◯ VERY LOW	CRITICAL
Hospitalization (>24 hours for any cause) (follow-up: 29 days)												
1 [186]	randomized trials	not serious	not serious	not serious[b]	extremely serious[a]	none	2/125 (1.6%)	2/128 (1.6%)	**RR 1.02** (.15 to 7.16)	**0 fewer per 1000** (from 13 fewer to 96 more)	⊕◯◯◯ VERY LOW	CRITICAL
Progression to severe or critical disease—not reported												
–	–	–	–	–	–	–	–	–	–	–	–	CRITICAL
Serious adverse events (follow-up: 29 days)												
1 [186]	randomized trials	not serious	not serious	not serious	extremely serious[a]	none	3/243 (1.2%)	0/138 (0.0%)	**RR 3.41** (.17 to 67.50)	**12 more per 1000** (from 26 fewer to 2 fewer)[c]	⊕◯◯◯ VERY LOW	CRITICAL

Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RR, risk ratio.

[a]Small number of events; fragility present; this resulted in noninformative estimates rated down 3 times for imprecision [192].

[b]COVID-19–related hospitalizations is a surrogate for ICU admission, mechanical ventilation and death. The patients studied were at average risk (not high risk) for severe disease. Not rated down for indirectness.

[c]Absolute effect calculated not using RR due to zero events on control group.

Table 27. GRADE Evidence Profile—Question: Bamlanivimab Compared to No Bamlanivimab for Nonhospitalized Persons With COVID-19 (*Last Updated 29 January 2021; Last Reviewed 19 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Bamlanivimab	No Bamlanivimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Hospitalization (including ED visits) with COVID-19 (follow-up: 29 days)												
1 [180]	randomized trials	not serious	not serious	serious[a]	very serious[b]	none	5/309 (1.6%)	9/143 (6.3%)	**RR 0.26** (.09 to .75)	**47 fewer per 1000** (from 57 fewer to 16 fewer)	⊕◯◯◯ VERY LOW	CRITICAL
Viral clearance (follow-up: 3 days; assessed with: change from baseline in SARS-CoV-2 viral load)												
1 [180]	randomized trials	not serious	not serious	serious[a,c]	serious[b]	none	309	143	…	**MD 0.49 lower** (0.87 lower to 0.11 lower)	⊕⊕◯◯ LOW	IMPORTANT
Viral clearance (follow-up: 11 days; assessed with: change from baseline in SARS-CoV-2 viral load)												
1 [180]	randomized trials	not serious	not serious	serious[a,c]	serious[d]	none	309	143	…	**MD 0.22 lower** (0.6 lower to 0.15 higher)	⊕⊕◯◯ LOW	IMPORTANT
Serious adverse events (upper abdominal pain)												
1 [180]	randomized trials	not serious	not serious	not serious	very serious[d]	none	0/309 (0.0%)	1/143 (0.7%)	**RR 0.15** (.01 to 3.78)	**6 fewer per 1000** (from 7 fewer to 19 more)	⊕⊕◯◯ LOW	CRITICAL
Infusion-related adverse events												
1 [180]	randomized trials	not serious	not serious	not serious	very serious[d]	none	7/309 (2.3%)	2/143 (1.4%)	**RR 1.62** (.34 to 7.70)	**9 more per 1000** (from 9 fewer to 94 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ED, emergency department; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; MD, mean difference; RR, risk ratio; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

[a]Uncertain that the treatment was provided in enough participants at risk of developing severe disease to be representative of the general population.

[b]The 95% CI may not include a meaningful difference. Few events reported suggests fragility of the estimate.

[c]Measure of viral clearance is a surrogate outcome for hospital admission, need for intensive care, intubation, and death.

[d]The 95% CI includes values that suggest either an increase or decrease in harm. Few events reported suggests fragility of the estimate.

Table 28. GRADE Evidence Profile—Question: Bamlanivimab Monotherapy Compared to No Bamlanivimab Monotherapy for Patients Hospitalized for COVID-19 (*Last Updated 29 January 2021; Last Reviewed 19 September 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Bamlanivimab	No Bamlanivimab	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality												
1 [181]	randomized trials	not serious	not serious	not serious	serious[a]	none	9/163 (5.5%)	5/151 (3.3%)	**HR 2.00** (.67 to 5.99)	**32 more per 1000** (from 11 fewer to 150 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Clinical improvement at day 5 (assessed with pulmonary ordinal outcome [scale 1–7; 1 = least severe])												
1 [181]	randomized trials	not serious	not serious	not serious	serious[a]	none	161	150	**OR 0.85** (.56 to 1.29)[b]	…	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events (follow-up: 5 days)												
1 [181]	randomized trials	not serious	not serious	not serious	serious[a]	none	4/163 (2.5%)	2/151 (1.3%)	**RR 1.85** (.34 to 9.97)	**11 more per 1000** (from 9 fewer to 119 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events (follow-up: 28 days)												
1 [181]	randomized trials	not serious	not serious	not serious	serious[a]	none	5/163 (3.1%)	5/151 (3.3%)	**RR 0.93** (.27 to 3.14)	**2 fewer per 1000** (from 24 fewer to 71 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Infusion-related adverse events												
1 [181]	randomized trials	not serious	not serious	not serious	serious[a]	none	23/163 (14.1%)	21/151 (13.9%)	**OR 1.64** (.79 to 3.44)[c]	**70 more per 1000** (from 26 fewer to 218 more)	⊕⊕⊕◯ MODERATE	IMPORTANT

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ED, emergency department; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; OR, odds ratio; RR, risk ratio.

[a]The 95% CI includes the potential for both appreciable benefit as well as the potential for harm. Few events reported do not meet the optimal information size and suggest fragility of the estimate.

[b]Study-provided OR adjusted for baseline ordinal category and trial pharmacy.

[c]Study-provided OR adjusted for the trial pharmacy.

Table 29. GRADE Evidence Profile, Recommendation 23—Question: Baricitinib Compared to No Baricitinib for Hospitalized Patients Receiving Standard of Care for Severe COVID-19 (*Last Reviewed and Updated 29 April 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Baricitinib	No Baricitinib	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: range 28 days to 60 days)												
2 [207, 208]	randomized trials	not serious	not serious	not serious	serious[a]	none	592/4912 (12.1%)	662/4769 (13.9%)	**RR 0.87** (.78 to .96)	**18 fewer per 1000** (from 31 fewer to 6 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Mechanical ventilation (follow-up: 28 days)												
1 [208]	randomized trials	not serious	not serious	not serious	serious[a]	none	283/4014 (7.1%)	322/3891 (8.3%)	**RR 0.85** (.73 to .99)	**12 fewer per 1000** (from 22 fewer to 1 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Disease progression (follow-up: 28 days; assessed with: progression to high-flow oxygen, noninvasive ventilation oxygen, invasive mechanical ventilation, or death)												
1 [201]	randomized trials	not serious	not serious	not serious	serious[a]	none	212/764 (27.7%)	232/761 (30.5%)	**OR 0.85** (.67 to 1.08)[b]	**33 fewer per 1000** (from 78 fewer to 17 more)	⊕⊕⊕◯ MODERATE	IMPORTANT
Serious adverse events (follow-up: 28 days)												
1 [201]	randomized trials	not serious	not serious	not serious	serious[c,d]	none	110/750 (14.7%)[e]	135/752 (18.0%)	**RR 0.82** (.65 to 1.03)	**32 fewer per 1000** (from 63 fewer to 5 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; OR, odds ratio; RR, risk ratio.

[a]95% CI cannot exclude no benefit.

[b]Multiple imputation includes n = 756 for placebo and n = 762 for baricitinib.

[c]Number of events does not meet optimal information size.

[d]95% CI cannot exclude no harm.

[e]Noncomparative serious adverse events were reported in the RECOVERY 2022 trial (baricitinib n = 4148): 13 total (5 serious infections, 3 bowel perforations, 2 pulmonary embolisms, and 1 each of ischemic colitis, elevated transaminases, and seizure).

Table 30. GRADE Evidence Profile, Recommendation 23—Question: Baricitinib Compared to No Baricitinib for Critically Ill (OS7) Patients With COVID-19 Pneumonia Requiring Invasive Mechanical Ventilation (*Last Reviewed and Updated 29 April 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Baricitinib	no baricitinib	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (HR) (follow-up: 60 days)												
2 [208, 209]	randomized trials	not serious	not serious	not serious	serious[a]	none	61/185 (33.0%)	75/167 (44.9%)	**RR 0.74** (.57 to .97)	**117 fewer per 1000** (from 193 fewer to 13 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL
Invasive mechanical ventilation–free days (follow-up: 60 days)												
1 [209]	randomized trials	not serious	not serious	not serious	very serious[a,b]	none	51	50	…	**MD 2.36 vent free days more** (6.1 more to 1.4 fewer)[c]	⊕⊕◯◯ LOW	IMPORTANT
Days of hospitalization (follow-up: 60 days)												
1 [209]	randomized trials	not serious	not serious	not serious	very serious[a,d]	none	51	50	…	**MD 2.3 d fewer** (4.6 fewer to 0)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: 28 days)												
1 [209]	randomized trials	not serious	not serious	not serious	serious[a]	none	25/50 (50.0%)	35/49 (71.4%)	**RR 0.70** (.50 to 0.97)	**214 fewer per 1000** (from 357 fewer to 21 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; MD, mean difference; RR, risk ratio.

[a]Few number of events, does not meet optimal information size.

[b]Pooled mortality event data (RR: 0.73; 95% CI: .50, 1.06) cannot exclude no meaningful benefit and therefore suggests fragility when compared with the HR.

[c]95% CI includes both the possibility of benefit and risk of harm.

[d]Adjusted for age (<65, ≥65) and region (United States, rest of the world).

Table 31. GRADE Evidence Profile, Recommendation 24—Question: Baricitinib With Remdesivir Compared to Remdesivir for Hospitalized Patients With COVID-19 (*Last Updated 16 May 2021; Last Reviewed 11 October 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Baricitinib + RDV	RDV	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
1 [206]	randomized trials	not serious	not serious	not serious	serious[a]	none	24/515 (4.7%)	37/518 (7.1%)	**HR 0.65** (.39 to 1.09)	**24 fewer per 1000** (from 43 fewer to 6 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Clinical recovery—hospitalized requiring supplemental O_2/receiving noninvasive ventilation or high-flow O_2 (ordinal 5 + 6) (assessed with: OS <4)												
1 [206]	randomized trials	serious[b]	not serious	not serious	serious[c]	none	344/391 (88.0%)	316/389 (81.2%)	**RR 1.08** (1.02 to 1.15)	**65 more per 1000** (from 16 more to 122 more)	⊕⊕◯◯ LOW	CRITICAL
Clinical recovery—receiving noninvasive ventilation or high-flow O_2, invasive mechanical ventilation or ECMO (ordinal 6 + 7; stratified) (assessed with: OS <4)												
1 [206]	randomized trials	not serious[d]	not serious	not serious	serious[e]	none	122/176 (69.3%)	114/191 (59.7%)	**HR 1.29** (1.00 to 1.66)[d]	**93 more per 1000** (from 0 fewer to 182 more)	⊕⊕⊕◯ MODERATE	CRITICAL
New use of mechanical ventilation or ECMO (follow-up: 29 days)												
1 [206]	randomized trials	serious[f]	not serious	not serious	serious[g]	none	46/461 (10.0%)	70/461 (15.2%)	**RR 0.66** (.46 to .93)	**52 fewer per 1000** (from 82 fewer to 11 fewer)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: 28 days)												
1 [206]	randomized trials	not serious	not serious	not serious	serious[g]	none	81/507 (16.0%)	107/509 (21.0%)	**RR 0.76** (.59 to .99)[h]	**50 fewer per 1000** (from 86 fewer to 2 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ECMO, extracorporeal membrane oxygenation; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; OS, ordinal scale; RDV, remdesivir; RR, risk ratio.

[a]95% CI includes substantial benefits as well as substantial harms.

[b]Nonstratified subgroup post hoc analysis.

[c]Lower boundary of the 95% CI crosses our threshold for a meaningful difference.

[d]Data from Table S6 in Kalil et al [206]. Although described as "analysis as randomized" in this stratum of severe COVID-19 patients, the analysis included moving patient from a baseline of "moderate" to "severe" post hoc (19 in the baricitinib group vs 21 in the placebo group), thus altering the original stratification. However, re-analysis using original strata data (OS 6 and 7 from Table 2) and 28-day cutoff (as a binary, non–time-to-event analysis) produces a similar result (RR: 1.2, 95% CI: 1.005 to 1.43). Not rated down for post hoc analysis concerns.

[e]95% CI includes substantial benefits as well as no effect.

[f]Not a predefined stratum. Secondary analysis.

[g]Less than 300 events; concern for fragility.

[h]Serious adverse events in 5 or more participants in any preferred term by treatment group: 6/507 were thought related to study drug in the baricitinib group; 5/509 were thought to be related to the study drug in the placebo group.

Table 32. GRADE Evidence Profile, Recommendation 25—Question: Tofacitinib Compared to No Tofacitinib for Hospitalized Patients With COVID-19 (*Last Reviewed and Updated 21 August 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Tofacitinib	No Tofacitinib	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Death or respiratory failure (follow-up: 28 days)												
1 [210]	randomized trials	not serious	not serious	not serious	very serious[a,b]	none	26/144 (18.1%)	42/145 (29.0%)	**RR 0.63** (.41 to .97)	**107 fewer per 1000** (from 171 fewer to 9 fewer)	⊕⊕◯◯ LOW	CRITICAL
Mortality (follow-up: 28 days)												
1 [210]	randomized trials	not serious	not serious	not serious	very serious[a,c]	none	4/144 (2.8%)	8/145 (5.5%)	**RR 0.49** (0.15 to 1.63)	**28 fewer per 1000** (from 47 fewer to 35 more)	⊕⊕◯◯ LOW	CRITICAL
Progression to mechanical ventilation or ECMO (follow-up: 28 days)												
1 [210]	randomized trials	not serious	not serious	not serious	very serious[a]	none	1/144 (0.7%)	4/145 (2.8%)	**RR 0.25** (.03 to 2.20)	**21 fewer per 1000** (from 27 fewer to 33 more)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: 28 days)												
1 [210]	randomized trials	not serious	not serious	not serious	very serious[a,c]	none	20/142 (14.1%)[d]	17/142 (12.0%)	**RR 1.18** (.64 to 2.15)	**22 more per 1000** (from 43 fewer to 138 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; ECMO, extracorporeal membrane oxygenation; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]Small number of events; fragility present.

[b]Upper boundary of the 95% CI crosses a threshold of meaningful effect.

[c]95% CI cannot exclude no harm.

[d]One Deep Vein Thrombosis (DVT) was observed in the tofacitinib group vs zero in the placebo group.

should be reserved for patients who cannot take corticosteroids because dexamethasone has been proven to reduce mortality in patients hospitalized with COVID-19 who require supplemental oxygen or mechanical ventilation and, for this reason, dexamethasone is recommended by the panel for this group. It is uncertain whether baricitinib plus remdesivir will have the same benefit as dexamethasone. As of the time of this narrative, there are no head-to-head trials evaluating either the combination of baricitinib plus tocilizumab or evaluating baricitinib compared with tocilizumab. A post hoc subgroup analysis in the RECOVERY trial showed no difference in measured outcomes with concomitant baricitinib and tocilizumab, but further well-done studies are needed [208].

Janus Kinase Inhibitors: Tofacitinib

Section last reviewed and updated 21 August 2021
Last literature search conducted 31 July 2021

Recommendation 26: Among hospitalized adults with severe* COVID-19 but not on noninvasive or invasive mechanical ventilation, the IDSA panel suggests tofacitinib rather than no tofacitinib. (conditional recommendation†, low certainty of evidence)

Remarks:

- Tofacitinib appears to demonstrate the most benefit in those with severe COVID-19 on supplemental or high-flow oxygen.
- Patients treated with tofacitinib should be on at least prophylactic dose anticoagulant.
- Patients who receive tofacitinib should not receive tocilizumab or other IL-6 inhibitor for treatment of COVID-19.
- The STOP-COVID trial did not include immunocompromised patients.

Severity definitions:

**Severe illness is defined as patients with $SpO_2 \leq 94\%$ on room air, including patients on supplemental oxygen or oxygen through a high-flow device.*

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Tofacitinib Considered for Treatment?

Tofacitinib is a JAK inhibitor that preferentially inhibits JAK-1 and JAK-3, although it is active on all other JAK isoforms. It is FDA-approved for moderate to severe RA, active psoriatic arthritis, and moderate to severe ulcerative colitis. Like baricitinib, it is expected that JAK inhibition leads to downstream suppression of cytokine production, thereby modulating the inflammatory cascade that results in systemic inflammation in patients with severe COVID-19. See the baricitinib section (above) for additional rationale on considerations for treatment.

Summary of the Evidence

Our literature search identified 1 RCT that compared the use of tofacitinib 10 mg every 12 hours for up to 14 days or placebo [210]. Patients included were those who had laboratory-confirmed SARS-CoV-2 infection and evidence of COVID-19 pneumonia on imaging and who were hospitalized for less than 72 hours. Patients in this study could not be receiving noninvasive ventilation, mechanical ventilation, or ECMO at baseline. Additionally, patients with a history of or current thrombosis, personal or first-degree family history of blood clotting disorders, immunosuppression, any active cancer, or those with certain cytopenias were excluded from this trial. Patients who received other potent immunosuppressants, or other biologic agents, were excluded, while the use of glucocorticoids for the management of COVID-19 was permitted. A composite outcome of death at day 28 or respiratory failure (defined as progression to NIAID OS 6, 7, or 8) was the primary outcome.

Benefits

Treatment of hospitalized patients with COVID-19 pneumonia with tofacitinib resulted in a lower risk of the composite outcome of death or respiratory failure compared with no tofacitinib (RR: .63; 95% CI: .41, .97; low CoE). However, results failed to show or to exclude a beneficial or detrimental effect on mortality alone (RR: .49; 95% CI: .15, 1.63; low CoE) or progression to mechanical ventilation or ECMO by day 28 (RR: .25; 95% CI: .03, 2.20; low CoE).

Harms

Patients who received tofacitinib experienced more serious adverse events; however, this may not be meaningfully different from those who received placebo (RR: 1.18; 95% CI: .64, 2.15; low CoE). Use of tofacitinib for other indications has shown an increase in thrombotic events, which prompted a black box warning by the FDA [211, 212]. As COVID-19 infection itself increases the risk for VTE events; it is important to note that the patients studied were either on prophylactic or full-dose anticoagulation during treatment with tofacitinib.

Tofacitinib carries 5 black-box warnings for its labeled indications, including a warning for (1) serious infections including tuberculosis, invasive fungal infections, bacterial, viral, and other opportunistic pathogens; (2) mortality; (3) thrombosis; and (4) lymphoma and other malignancies, including an increased rate of Epstein-Barr virus–mediated post-transplant lymphoproliferative disorder [211–214].

Other Considerations

The panel agreed that the overall CoE was low due to concerns of imprecision, which recognized the limited number of events, and concerns about fragility of the results in the group who likely would benefit the most (those requiring supplemental oxygen or oxygen through a high-flow device).

Conclusions and Research Needs for This Recommendation

The guideline panel suggests tofacitinib in addition to standard of care for patient hospitalized for severe COVID-19. Due to the increased risk of VTE with treatment with tofacitinib, patients should receive at least prophylactic doses of anticoagulants during their hospital stay. Patients who received JAK inhibitors should not receive tocilizumab or other immunomodulators as no adequate evidence is available for its combined use (Table 32).

Ivermectin

Section last reviewed and updated 30 June 2022
Last literature search conducted 31 May 2022

Recommendation 26: In hospitalized patients with COVID-19, the IDSA panel suggests against ivermectin. (conditional recommendation††, very low certainty of evidence)

Recommendation 27: In ambulatory persons with COVID-19, the IDSA panel recommends against ivermectin. (strong recommendation, moderate certainty of evidence)

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Ivermectin Considered for Treatment?

Ivermectin is an antiparasitic agent that is FDA-approved for onchocerciasis and strongyloidiasis and is used off-label for the treatment of many parasitic infections. Although it has in vitro activity against some viruses, including SARS-CoV-2, it has no proven therapeutic utility. In vitro activity against SARS-CoV-2 [215] requires concentrations considerably higher than those achieved in human plasma and lung tissue to reach the in vitro Inhibitory Concentration 50% [216]. Ivermectin has been shown to have anti-inflammatory effects in in vitro and in vivo studies, hence hypothesized to have a mechanism beyond its antiviral effects in the treatment of COVID-19 [217, 218].

Since ivermectin is generally well tolerated, it was empirically evaluated in uncontrolled studies for COVID-19, alone and in combination with other off-label medications.

Summary of the Evidence

Our search identified 21 studies in patients with COVID-19 with ages ranging between 8 and 86 years that reported on the outcomes of mortality, symptom resolution, viral clearance, and adverse events, and informed the evidence review for inpatient and outpatient therapy [219–239]. Eligible studies compared treatment with ivermectin against a placebo or standard of care. Studies comparing ivermectin to a non-placebo, active comparison (ie, a different agent considered a possible treatment for COVID-19 infection by clinicians), or that did not provide a comparison arm were not included in these analyses. Several studies did not meet eligibility for inclusion in this review. Three trials compared ivermectin with HCQ (comparison to treatment with evidence of harm) [240–242]; 2 trials examined ivermectin as prophylactic treatment [243, 244]; and 2 trials did not provide study data in a peer-reviewed, published, or preprint manuscript [242, 245].

The studies that informed the recommendations for hospitalized patients included 11 RCTs [219–223, 227–230, 238, 239]. Twelve RCTs [221, 222, 224–226, 231–237] informed the recommendation for ambulatory persons. Each of them compared an active treatment arm of ivermectin with an inactive comparison (eg, standard of care with or without placebo).

The evidence informing the recommendations for treating hospitalized and ambulatory persons with ivermectin reported on the use of a range of doses (100 µg/kg/day to 400 µg/kg/day) and durations (1 day up to 7 days). Among studies reporting on hospitalized patients, substantial heterogeneity was observed, introduced by 1 study (Supplementary Figure 10c) [219]. Ahmed et al [219] treated patients with ivermectin for a duration of 5 days, rather than 1 day as used by the remaining studies. This may explain the heterogeneity between studies; however, excluding Ahmed et al, any meaningful reduction in viral clearance was still not demonstrated by the summary estimate (Supplementary Figure 10d). Heterogeneity was not observed for other outcomes reported for hospitalized or ambulatory persons.

Among the RCTs, the risk of bias was high in 2 trials because of unsuccessful randomization into treatment and control groups. Hashim et al [222] inadequately randomized participants by allocating them to respective treatment arms on odd and even days, as well as assigning all critically ill patients to the ivermectin arm; and Podder et al [223] allocated participants based on odd or even registration numbers. In addition, across many RCTs, there were concerns due to lack of blinding of study personnel, which may lead to over- or underestimates of treatment effects, particularly for subjective outcomes (eg, symptom resolution, adverse events).

Benefits

Hospitalized. The evidence from RCTs failed to demonstrate a meaningful effect on mortality or need for mechanical ventilation among persons with COVID-19 (RR: .54; 95% CI: .28, 1.03 [moderate CoE]; and RR: .40; 95% CI: .13, 1.27 [low CoE], respectively). Persons receiving treatment with ivermectin rather

Table 33. GRADE Evidence Profile, Recommendation 26—Question: Ivermectin Compared to No Ivermectin for Patients Hospitalized With COVID-19 (*Last Reviewed and Updated 25 May 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Ivermectin	No Ivermectin	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)												
8 [221, 222, 227–230, 238, 239]	randomized trials	not serious	not serious	not serious	serious[a]	none	13/593 (2.2%)	26/546 (4.8%)	**RR 0.54** (.28 to 1.03)	**22 fewer per 1000** (from 34 fewer to 1 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Need for mechanical ventilation (follow-up: 28 days)												
2 [238, 239]	randomized trials	not serious	not serious	not serious	very serious[a]	none	4/283 (1.4%)	10/285 (3.5%)	**RR 0.40** (.13 to 1.27)	**21 fewer per 1000** (from 31 fewer to 9 more)	⊕⊕◯◯ LOW	CRITICAL
Symptom resolution (follow-up: 7 days)												
1 [220]	randomized trials	serious[b]	not serious	not serious	very serious[a]	none	16/25 (64.0%)	15/25 (60.0%)	**RR 1.07** (.69 to 1.65)	**42 more per 1000** (from 186 fewer to 390 more)	⊕◯◯◯ VERY LOW	CRITICAL
Viral clearance at day 7 (RCT) (follow-up: range 7 days to 29 days)												
5 [219, 221, 223, 227, 239]	randomized trials	serious[c]	serious [d]	serious [e]	very serious[a]	none	65/170 (38.2%)	44/136 (32.4%)	**RR 1.22** (.72 to 2.09)	**71 more per 1000** (from 91 fewer to 353 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Serious adverse events (follow-up: 28 days)												
4 [219, 229, 238, 239]	randomized trials	not serious	not serious	not serious	serious[a]	none	5/319 (1.6%)	1/312 (0.3%)	**RR 3.10** (.54 to 17.89)	**7 more per 1000** (from 1 fewer to 54 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RCT, randomized controlled trial; RR, risk ratio.

[a]The 95% CI cannot exclude no meaningful effect. Few events reported do not meet the optimal information size and suggest fragility of the estimate.

[b]Open-label trial may lead to bias with measurement of subjective outcomes.

[c]Podder et al [223] assigns participants based on odd or even registration numbers; also, 20 patients were excluded following randomization without sensitivity analysis to explore imbalance across treatment arms.

[d]Substantial heterogeneity observed ($I^2 = 62\%$). Possibly explained by the longer duration of treatment (5 days compared to 1 day) in Ahmed et al [219].

[e]Viral clearance is a surrogate for clinical improvement, such as hospitalization, need for ICU care, and mechanical ventilation.

Table 34. GRADE Evidence Profile, Recommendation 27—Question: Ivermectin Compared to No Ivermectin for Ambulatory Persons for Management of COVID-19 (*Last Reviewed and Updated 13 June 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Ivermectin	No Ivermectin	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality												
10 [221, 222, 224–226, 231–237]	randomized trials	not serious[a]	not serious	not serious	not serious	none	27/2410 (1.1%)	36/2372 (1.5%)	**RR 0.83** (.50 to 1.37)	**3 fewer per 1000** (from 8 fewer to 6 more)	⊕⊕⊕⊕ HIGH	CRITICAL
Progression to severe disease (assessed with need for invasive ventilation)												
6 [221, 222, 225, 226, 232, 234]	randomized trials	not serious	not serious	not serious	serious[b]	none	28/1244 (2.3%)	40/1245 (3.2%)	**RR 0.72** (.44 to 1.17)	**9 fewer per 1000** (from 18 fewer to 5 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalization (follow-up: 28 days)												
2 [234, 237]	randomized trials	not serious	not serious	not serious	serious[b]	none	89/1496 (5.9%)	104/1453 (7.2%)	**RR 0.85** (.65 to 1.11)	**11 fewer per 1000** (from 25 fewer to 8 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Viral clearance at day 7 (RCT) (follow-up: range 6 days to 29 days)												
5 [221, 224, 225, 233, 234]	randomized trials	not serious	not serious	serious[c,d]	very serious[b]	none	108/306 (35.3%)	103/326 (31.6%)	**RR 1.11** (.85 to 1.44)	**35 more per 1000** (from 47 fewer to 139 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Time to recovery (assessed with: days)												
3 [222, 226, 231]	randomized trials	serious[e]	serious[f]	not serious[g]	serious[h]	none	448	446	…	**MD 3.46 d fewer** (5.4 fewer to 1.52 fewer)[i]	⊕◯◯◯ VERY LOW	IMPORTANT
Serious adverse events (respiratory failure, sepsis, multiorgan failure, etc)												
6 [221, 224, 226, 234, 236, 237]	randomized trials	not serious	not serious	not serious	serious[j]	none	31/1740 (1.8%)	40/1719 (2.3%)	**RR 0.81** (.51 to 1.30)	**4 fewer per 1000** (from 11 fewer to 7 more)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; ICU, intensive care unit; MD, mean difference; RCT, randomized controlled trial; RR, risk ratio.

[a]Concerns with unmeasured and residual confounding. Hashim et al [222] used even vs odd days to place subjects into treatment groups with critical patients not included in the placebo group.

[b]The 95% CI includes the potential for both appreciable benefit as well as the potential for harm. Few events reported do not meet the optimal information size and suggest fragility of the estimate.

[c]Viral clearance is a surrogate for clinical improvement, such as hospitalization, need for ICU care, and mechanical ventilation.

[d]Ravikirti and Pattadar [225] reported viral clearance at day 6.

[e]Open-label trial may lead to bias with measurement of subjective outcomes.

[f]High heterogeneity $I^2 = 96$.

[g]Ivermectin was combined with doxycycline.

[h]Number of events is less than the optimal information size, which may suggest fragility in the estimate of effect.

[i]The binary endpoint of time to recovery from the ACTIV-6 trial could not be combined with pooled continuous analysis of days to recovery; however, did not show a reduction with an HR of 1.09 (0.98, 1.22).

[j]The 95% CI cannot exclude the potential of increased serious adverse events in the treatment arm. Few events suggest fragility in the estimate.

Table 35. GRADE Evidence Profile, Recommendation 28—Question: Fluvoxamine Compared to No Fluvoxamine for Ambulatory Patients With COVID-19 (*Last Reviewed and Updated 8 November 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Fluvoxamine	no Fluvoxamine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality (follow-up: 28 days)[a]												
2 [251, 252]	randomized trials	not serious	not serious	not serious	very serious[b]	none	17/821 (2.1%)	25/828 (3.0%)	**RR 0.69** (.38 to 1.27)	**9 fewer per 1000** (from 19 fewer to 8 more)	⊕⊕◯◯ LOW	CRITICAL
Hospitalization, emergency room visits (>6 hours), or oxygen saturation <92% (follow-up: 28 days)[a]												
2 [251, 252]	randomized trials	not serious	not serious	serious[c]	serious[b]	none	79/821 (9.6%)	125/828 (15.1%)	**RR 0.64** (0.50 to 0.84)	**54 fewer per 1000** (from 75 fewer to 24 fewer)	⊕⊕◯◯ LOW	CRITICAL
Hospitalization for COVID-19 (follow-up: 28 days)[a]												
2 [251, 252]	randomized trials	not serious	not serious	not serious	very serious[b]	none	76/821 (9.3%)	103/828 (12.4%)	**RR 0.75** (.57 to .99)	**31 fewer per 1000** (from 53 fewer to 1 fewer)	⊕⊕◯◯ LOW	CRITICAL
Viral clearance (follow-up: 7 days)												
1 [252]	randomized trials	serious[d]	not serious	serious[e]	very serious[b]	none	40/207 (19.3%)	58/221 (26.2%)	**RR 0.74** (.52 to 1.05)	**68 fewer per 1000** (from 126 fewer to 13 more)	⊕◯◯◯ VERY LOW	IMPORTANT
Serious adverse events[a]												
2 [251, 252]	randomized trials	not serious	not serious	not serious	very serious[f]	none	60/821 (7.3%)	75/828 (9.1%)	**RR 0.81** (.59 to 1.12)	**17 fewer per 1000** (from 37 fewer to 11 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings may be derived from evidence that includes preprint articles, which have not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RR, risk ratio.

[a]Lenze et al [251] had a 15-day follow-up period; Reis et al [252] had a 28-day follow-up period. Serious adverse events for Reis et al included only the nonmortal grade 4 and grade 3 treatment emergent adverse events.

[b]95% CI includes both the potential for benefit and the risk of harms; few events suggest fragility of the estimate.

[c]Hospitalization, emergency room visits are surrogate marker for clinical deterioration leading to ICU care, ventilation, and mortality. In addition, best supportive care may have been substantially different in Brazil at that time compared with the US health system.

[d]Data available for approximately 1/3 of study population per treatment group.

[e]Viral clearance is a surrogate for clinical improvement, such as hospitalization, need for ICU care, and mechanical ventilation.

[f]95% CI cannot exclude the possibility of meaningful harm.

Paxlovid is authorized for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death.

Figure 8. FDA EUA criteria for the use of nirmatrelvir/ritonavir co-packaged as Paxlovid™ (Pfizer) [253]. Abbreviations: COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

than no ivermectin failed to demonstrate a beneficial or detrimental effect on symptom resolution or viral clearance at day 7 (RR: 1.07; 95% CI: .69, 1.65 [very low CoE]; and RR: 1.21; 95% CI: .77, 1.90 [very low CoE], respectively).

Ambulatory

Treatment with ivermectin does not reduce mortality (RR: .83; 95% CI: .50, 1.37; high CoE). Treatment with ivermectin may reduce progression to severe disease; however, the evidence failed to demonstrate a beneficial or detrimental effect on symptoms (RR: .72; 95% CI: .44, 1.17; moderate CoE). Treatment with ivermectin failed to demonstrate a beneficial or detrimental effect on hospitalization or viral clearance at day 7 (RR: .85; 95% CI: .65, 1.11 [moderate CoE]; and RR: 1.11; 95% CI: .85, 1.44 [very low CoE], respectively). The evidence is very uncertain, but ivermectin may reduce the time to recovery among ambulatory persons with COVID-19 (MD: 3.46 days fewer; 95% CI: 5.40 to 1.52 days fewer; very low CoE). However, the ACTIV-6 trial did not show a reduction in time to recovery, with an HR of 1.09 (95% CI: .98, 1.22) [237].

Harms

In doses typically used for the treatment of parasitic infections, ivermectin is well tolerated. We are unable to exclude the potential for serious adverse events in hospitalized patients and ambulatory persons with COVID-19 treated with ivermectin rather than no ivermectin (RR: 3.10; 95% CI: .54, 17.89 [moderate CoE]; and RR: .81; 95% CI: .51, 1.30 [moderate CoE], respectively).

Other Considerations

The panel determined the CoE of treatment of ivermectin for hospitalized patients to be very low due to concerns with risk of bias (ie, study limitations) and imprecision. However, the panel's decision for hospitalized patients was indirectly informed by the lack of benefit of ivermectin as seen in studies in ambulatory persons. The panel determined the CoE of treatment of ivermectin for ambulatory persons to be moderate due to concerns with imprecision. The guideline panel made a conditional recommendation against treatment of COVID-19 with ivermectin outside of the context of a clinical trial for both patients with COVID-19 who are hospitalized or in the outpatient setting.

Conclusions and Research Needs for This Recommendation

The guideline panel suggests against ivermectin for the treatment of hospitalized patients with COVID-19. The guideline panel recommends against ivermectin for the treatment of outpatients with COVID-19 (Tables 33 and 34).

Fluvoxamine

Section last reviewed and updated 8 November 2021
Last literature search conducted 31 October 2021

Recommendation 28: Among ambulatory patients with COVID-19, the IDSA guideline panel recommends fluvoxamine only in the context of a clinical trial. (knowledge gap)

Why Is Fluvoxamine Considered for Treatment?

Fluvoxamine is a selective serotonin reuptake inhibitor (SSRI), which is currently FDA-approved for the treatment of obsessive-compulsive disorder. SSRIs have been shown to have affinity for Sigma-1 receptors, which have been demonstrated to modulate cytokine levels in animal models of septic shock [246]. Additionally, pharmacologic agents that act at Sigma-1 receptors have demonstrated in vitro activity against SARS-CoV-2 [247]. Among the SSRIs, fluvoxamine has been shown to have a high affinity for these receptors, making it a potential repurposed drug option for the management of COVID-19 [248]. SSRIs like fluvoxamine may decrease uptake of serotonin from platelets during thrombosis, resulting in decreased neutrophil recruitment and platelet aggregation, which may be helpful in the early stages of COVID-19 [249, 250].

Summary of the Evidence

Our search identified 2 RCTs that reported on ambulatory patients with SARS-CoV-2 infection [251, 252]. Patients in these studies were randomized to fluvoxamine or placebo/usual care. Both trials included symptomatic outpatients who tested positive for SARS-CoV-2 infection within 7 days. Reis et al [252] included patients who were at high risk for severe infection and utilized a composite primary outcome of hospitalization or emergency room visit lasting greater than 6 hours. Additional outcomes reported in the 2 trials included mortality,

- Alpha1-adrenoreceptor antagonist: alfuzosin
- Antianginal: ranolazine
- Antiarrhythmic: amiodarone, dronedarone, flecainide, propafenone, quinidine
- Anti-gout: colchicine
- Antipsychotics: lurasidone, pimozide
- Benign prostatic hyperplasia agents: silodosin
- Cardiovascular agents: eplerenone, ivabradine
- Ergot derivatives: dihydroergotamine, ergotamine, methylergonovine
- HMG-CoA reductase inhibitors: lovastatin, simvastatin
- Immunosuppressants: voclosporin
- Microsomal triglyceride transfer protein inhibitor: lomitapide
- Migraine medications: eletriptan, ubrogepant
- Mineralocorticoid receptor antagonists: finerenone
- Opioid antagonists: naloxegol
- PDE5 inhibitor: sildenafil (Revatio®) when used for pulmonary arterial hypertension (PAH)
- Sedative/hypnotics: triazolam, oral midazolam
- Serotonin receptor 1A agonist/serotonin receptor 2A antagonist: flibanserin
- Vasopressin receptor antagonists: tolvaptan

Figure 9. Nirmatrelvir/ritonavir is contraindicated with drugs that are highly dependent on CYP3A for clearance and for which elevated concentrations are associated with serious and/or life-threatening reactions [253]. Note: Please check drug interactions before initiating nirmatrelvir/ritonavir as the table above does not list all therapeutic agents or classes with potential interactions; see Liverpool COVID-19 interactions website (https://www.COVID19-druginteractions.org/checker).

hospitalization, emergency room visit lasting more than 6 hours, progression to oxygen saturation of less than 92%, viral clearance, and serious adverse events.

Benefits

Outpatients. Among symptomatic ambulatory patients with COVID-19, fluvoxamine failed to demonstrate or to exclude a beneficial effect on mortality at 28 days compared with no fluvoxamine (RR: .69; 95% CI: .38, 1.27; low CoE). Fluvoxamine showed a reduction of the composite outcome of hospitalizations, emergency room visits lasting more than 6 hours, or oxygen saturation of less than 92% (RR: .64; 95% CI: .50, .84; low CoE). When evaluating the effect on hospitalizations only, there was a trend toward fewer hospitalizations in fluvoxamine-treated patients compared with those not receiving fluvoxamine (RR: .75; 95% CI: .57, .99; low CoE). Treatment with fluvoxamine failed to show a benefit in viral clearance at day 7 (RR: .74; 95% CI: .52, 1.05; very low CoE).

Harms. The risk of serious adverse events in patients receiving fluvoxamine was not greater than in those not receiving fluvoxamine (RR: .81; 95% CI: .59, 1.12; low CoE).

Other Considerations. The panel agreed on the overall low CoE given the sparseness in mortality data and because the upper boundary of the 95% CI failed to exclude the risk of possible harms. The panel also had concerns about the generalizability/indirectness in the results surrounding hospitalization and emergency room visit of more than 6 hours as 1 study [252] was partially conducted in patients with extended stays in emergency settings (mobile hospitals) to inform the primary endpoint, and it is unclear if resource constraints (possible contingency setting) may have affected the total number of events (ie, emergency room stays and rates of hospitalization).

Conclusions and Research Needs for This Recommendation

The guideline panel recommends fluvoxamine only in the context of a clinical trial to better delineate the effects of

- Anticancer drugs: apalutamide
- Anticonvulsant: carbamazepine, phenobarbital, primidone, phenytoin
- Cystic fibrosis transmembrane conductance regulator potentiators: lumacaftor/ivacaftor
- Antimycobacterials: rifampin
- Herbal products: St. John's Wort (hypericum perforatum)

Figure 10. Nirmatrelvir/ritonavir is contraindicated with drugs that are potent CYP3A inducers where significantly reduced nirmatrelvir or ritonavir plasma concentrations may be associated with the potential for loss of virologic response and possible resistance [253].

fluvoxamine on disease progression, such as need for hospital admission, ICU care, and ultimately, mortality (Table 35).

Nirmatrelvir/Ritonavir

Section last reviewed and updated 29 December 2021
Last literature search conducted 28 December 2021

Resources:

- University of Liverpool: COVID-19 drug interaction checker.
- University of Liverpool: HIV drug interaction checker.

Recommendation 29: In ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel suggests nirmatrelvir/ritonavir initiated within 5 days of symptom onset rather than no nirmatrelvir/ritonavir. (conditional recommendation†, low certainty of evidence)

Remarks:

- Patients' medications need to be screened for serious drug interactions (ie, medication reconciliation). Patients on ritonavir- or cobicistat-containing HIV or hepatitis C virus regimens should continue their treatment as indicated.
- Dosing based on renal function:
  - eGFR >60 mL/minute: 300 mg nirmatrelvir/100 ritonavir every 12 hours for 5 days
  - eGFR ≤60mL/minute and ≥30 mL/minute: 150 mg nirmatrelvir/100 mg ritonavir every 12 hours for 5 days
  - eGFR <30 mL/minute: not recommended
- Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital for reasons other than COVID-19 may also receive nirmatrelvir/ritonavir (Figure 8).

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Nirmatrelvir/Ritonavir Considered for Treatment?

Nirmatrelvir is an inhibitor to the main protease (Mpro) of SARS-CoV-2; inhibition of this enzyme blocks viral replication. Nirmatrelvir is a substrate of the cytochrome P450 3A4 isoenzyme system and is co-packaged with an HIV-1 protease inhibitor, ritonavir, a potent inhibitor of cytochrome P450 3A4. Coadministration results in higher concentrations and a longer half-life of nirmatrelvir, allowing for every-12-hour dosing. The FDA granted EUA to nirmatrelvir/ritonavir on 22 December 2021 for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients who are at high risk for progression to severe COVID-19, including hospitalization or death [253].

Summary of the Evidence

Our search identified 1 RCT reporting on treatment of mild-to-moderate COVID-19 in patients at high risk for progression to severe disease [253]. Data have not yet been published, but data to prepare this recommendation were extracted from the FDA EUA document.

Benefits

Nirmatrelvir/Ritonavir. All-cause mortality through day 28 may be lower in patients receiving nirmatrelvir/ritonavir compared with no nirmatrelvir/ritonavir (RR: .04; 95% CI: .00, .69; low CoE). Patients treated with nirmatrelvir/ritonavir rather than no nirmatrelvir/ritonavir may have fewer COVID-19–related hospitalizations (RR: .12; 95% CI: .06, .26; low CoE). The composite endpoint of COVID-19–related hospitalizations or mortality was lower in patients receiving nirmatrelvir/ritonavir compared with no nirmatrelvir/ritonavir (RR: .12; 95% CI: .06, .25; low CoE).

Harms

Nirmatrelvir/Ritonavir. Serious treatment-emergent adverse events were not reported in the FDA EUA. Given coformulation with ritonavir as a pharmacokinetic booster, there is potential for significant drug interactions. Contraindications exist between agents that can have their levels increased or decreased by nirmatrelvir and/or ritonavir and agents that can speed up the metabolism of the components of nirmatrelvir and/or ritonavir, resulting in a loss of virologic response and

possible resistance. These drug interactions can result in treatment failure or serious adverse events, which may lead to severe, life-threatening, or fatal events from greater exposures (ie, higher levels) of concomitant medications. See Figures 9 and 10.

Less severe but clinically meaningful drug interactions may also occur when nirmatrelvir/ritonavir is co-administered with other agents. Levels of immunosuppressive agents, such as tacrolimus, cyclosporine, or sirolimus, can be increased when administered with nirmatrelvir/ritonavir. Hormonal contraceptives containing ethinyl estradiol may possibly have reduced effectiveness due to lowered ethinyl estradiol levels when administered with nirmatrelvir/ritonavir. Women of childbearing potential should be counseled to use a back-up, nonhormonal method of contraception.

Patients with moderate renal impairment (eGFR <60 and ≥30 mL/minute) will need to be counseled that they will only take one 150-mg nirmatrelvir tablet (oval shape, pink) with one 100 mg ritonavir twice daily, instead of the regular dose of two 150-mg nirmatrelvir (300 mg) tablets with one 100 mg ritonavir twice daily. When dispensing the product for patients with moderate renal impairment, pharmacists are instructed to alter the blister cards to ensure that patients receive the correct dose. Pharmacists need to adhere to the specific instructions when dispensing the product according to instructions provided in the EUA [254]. Given the lack of renal function/eGFR data at the point of dispensing, providers must specify the numeric dosage of each agent on the prescription to ensure the correct dose is provided to the patient at the point of dispensing. There are no data in patients with severe renal disease (eGFR ≤30 mL/minute) and this medication is currently not recommended in patients with severe renal disease until more data on dosing in this population are available.

There are no dose adjustments needed for patients with mild (Child-Pugh A) or moderate (Child-Pugh B) hepatic impairment; however, data are lacking in patients with Child-Pugh C and nirmatrelvir/ritonavir is therefore not recommended in this population.

According to the EUA, nirmatrelvir/ritonavir use may lead to a risk of HIV-1 developing resistance to HIV protease inhibitors in individuals with uncontrolled or undiagnosed HIV-1 infection.

Other Considerations

Nirmatrelvir/Ritonavir. The panel agreed that the overall CoE for the treatment of ambulatory patients was low; there are concerns with the inability to exclude potential risks to bias because of limited availability of study details within the EUA, and there is imprecision due to a low number of events reported. The EUA did not report safety data (eg, adverse events or severe adverse events) from the trial. The panel agreed that the benefits are likely to outweigh any potential harms in patients with COVID-19 who are at high risk of severe disease; however, recognized concerns with drug interactions must be considered.

The evidence confirms that using nirmatrelvir/ritonavir early in the disease process when viral loads are high confers maximum benefit. It is critical to make a rapid diagnosis and treat ambulatory patients with COVID-19 early in the disease course.

Conclusions and Research Needs for This Recommendation

Nirmatrelvir/Ritonavir. The guideline panel suggests the use of nirmatrelvir/ritonavir for ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease who are within 5 days of symptom onset. More data are needed on the potential adverse effects of this medication.

Molnupiravir

Section last reviewed and updated 28 December 2021
Last literature search conducted 28 December 2021

Recommendation 30: In ambulatory patients (≥18 years) with mild-to-moderate COVID-19 at high risk for progression to severe disease who have no other treatment options*, the IDSA guideline panel suggests molnupiravir initiated within 5 days of symptom onset rather than no molnupiravir. (conditional recommendation†, low certainty of evidence)

**Other options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, 3-day treatment with remdesivir, and neutralizing monoclonal antibodies. Patient-specific factors (eg, symptom duration, renal function, drug interactions) as well as product availability should drive decision making regarding choice of agent. Data for combination treatment do not exist in this setting.*

Remarks:

- Patients who put a higher value on the putative mutagenesis, adverse events, or reproductive concerns and a lower value on the uncertain benefits would reasonably decline molnupiravir.
- Molnupiravir 800 mg for 5 days.
- Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital for reasons other than COVID-19 may also receive molnupiravir.
- Molnupiravir is not authorized under the FDA EUA for use in patients <18 years because it may affect bone and cartilage growth.
- Molnupiravir is not recommended under the FDA EUA for use during pregnancy.
- Molnupiravir is not authorized under the FDA EUA for pre-exposure or postexposure prevention of COVID-19 or for initiation of treatment in patients hospitalized due

Molnupiravir is authorized for the treatment of mild-to-moderate coronavirus disease 2019 (COVID-19) in adults with positive results of direct SARS-CoV-2 viral testing who are at high risk for progression to severe COVID-19, including hospitalization or death, and for whom alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate.

Figure 11. FDA EUA criteria for the use of molnupiravir [255]. Abbreviations: COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

to COVID-19 because benefit of treatment has not been observed in individuals when treatment is started after hospitalization due to COVID-19 (Figure 11).

†*The guideline panel concluded that the desirable effects outweigh the undesirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Molnupiravir Considered for Treatment?

Molnupiravir is an oral antiviral that targets the genetic machinery that is responsible for SARS-CoV-2 replication. Molnupiravir is an oral pro-drug that is converted to β-D-N4-hydroxycytidine, which acts as a substrate for RNA-dependent RNA polymerase. After it is incorporated into the viral RNA, serial mutations develop, resulting in a virus that is less fit for ongoing viral replication. One phase I RCT evaluated the safety and tolerability of molnupiravir in healthy adults without COVID-19 [256]. The study reported molnupiravir to be well tolerated, with no increased reports of serious adverse events among persons in the molnupiravir arm compared with those receiving placebo. The FDA granted EUA to molnupiravir on 23 December 2021 for the treatment of mild-to-moderate COVID-19 in adults (≥18 years) who are at high risk for progression to severe COVID-19, including hospitalization or death.

Summary of the Evidence

Two RCTs reported on treatment of unvaccinated patients with COVID-19 with either 800 mg molnupiravir or placebo for 5 days [257, 258]. In 1 phase III trial (MOVe-OUT trial) reporting on the outcomes of death, hospitalization, and serious adverse events, patients with mild-to-moderate COVID-19 received either molnupiravir or placebo within 5 days after the onset of symptoms. In the phase IIa trial reporting on the outcomes of death and serious adverse events, patients with symptom duration of less than 7 days received molnupiravir or placebo.

Benefits

COVID-19–related mortality may be lower in patients receiving molnupiravir rather than placebo (RR: .11; 95% CI: .01, .86; low CoE). Similarly, COVID-19–related hospitalizations and the composite of all-cause hospitalization or death may trend towards a reduction among patients receiving molnupiravir rather than no molnupiravir (RR: .68; 95% CI: .48, 1.00 [low CoE]; and HR: .69; 95% CI: .48, 1.01 [low CoE], respectively).

Harms

Patients treated with molnupiravir may not experience greater serious adverse events than those receiving placebo (RR: .43; 95% CI: .17, 1.11; low CoE). Based on findings from animal reproduction studies, molnupiravir may cause fetal harm when administered to pregnant individuals [255]. Other concerns with molnupiravir include the possibility of viral mutagenesis in persons with compromised immune systems who are unable to clear the virus. Females of childbearing potential should be counseled to use a reliable method of contraception during treatment and for 4 days after the last dose. Men of reproductive potential who are sexually active with females of childbearing potential should be counseled to use a reliable method of contraception during treatment and for at least 3 months after the last dose of molnupiravir. It is also not recommended in children younger than 18 years of age for the concern of bone growth. Molnupiravir does not require renal or hepatic dose adjustment.

Other Considerations

The panel agreed that the overall CoE for treatment of ambulatory patients was low, given concerns with imprecision, driven by few reported events, and a relatively small effect.

The use of molnupiravir presents additional considerations and potential concerns regarding viral mutagenesis in immunocompromised persons and safety in persons of reproductive age, for which more data are needed to quantify such effects. The panel recognized that alternative treatment options exist with the possibility of greater benefit with a smaller known safety profile. The FDA required the manufacturers to conduct additional animal studies on the impact of the drug on spermatogenesis and to establish a pregnancy registry if the drug was inadvertently administered during pregnancy.

The evidence confirms that using molnupiravir early in the disease process when viral loads are high confers maximum benefit. It is critical to make a rapid diagnosis and treat ambulatory patients with COVID-19 early in the disease course.

Table 36. GRADE Evidence Profile, Recommendation 29—Question: Nirmatrelvir/Ritonavir Compared to No Nirmatrelvir/Ritonavir for Ambulatory Patients With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 3 February 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Nirmatrelvir/ Ritonavir	No Nirmatrelvir/ Ritonavir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
All-cause mortality (follow-up: 28 days)												
1 [253]	randomized trials	serious[a]	not serious	not serious[b]	serious[c]	none	0/1039 (0.0%)	12/1046 (1.1%)	**RR 0.04** (0.00 to 0.68)	**11 fewer per 1000** (from 18 fewer to 5 fewer)[d]	⊕⊕◯◯ LOW	CRITICAL
COVID-19–related hospitalizations (follow-up: 28 days)												
1 [253]	randomized trials	serious[a]	not serious	not serious[b,e]	serious[c]	none	8/1039 (0.8%)	65/1046 (6.2%)	**RR 0.12** (0.06 to 0.26)	**55 fewer per 1000** (from 58 fewer to 46 fewer)	⊕⊕◯◯ LOW	CRITICAL
COVID-19—related hospitalization or all-cause death (follow-up: 28 days)												
1 [253]	randomized trials	serious[a]	not serious	not serious[b]	serious[c]	none	8/1039 (0.8%)	66/1046 (6.3%)	**RR 0.12** (0.06 to 0.25)	**56 fewer per 1000** (from 59 fewer to 47 fewer)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events—not reported												
…	…	…	…	…	…	…	…	…	…	…	…	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; EUA, Emergency Use Authorization; FDA, Food and Drug Administration; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; ICU, intensive care unit; RR, risk ratio; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

[a]Evidence profile based on information reported in FDA EUA and due to limited available study details, unable to exclude potential risks of bias. Concerns about selective outcome reporting as hospitalization or death from any cause and all-cause mortality are reported out of 10 outcome measures identified in the trial protocol, including serious adverse events and adverse events.

[b]The primary SARS-CoV-2 variant across both treatment arms was Delta (98%), including clades 21J, 21A, and 21I.

[c]Small number of events; fragility present.

[d]Recalculated due to zero events in the intervention arm.

[e]COVID-19–related hospitalizations is a surrogate for ICU admission, mechanical ventilation, and death. Not rated down.

Table 37. GRADE Evidence Profile, Recommendation 30—Question: Molnupiravir Compared to No Molnupiravir for Ambulatory Patients With Mild-to-Moderate COVID-19 at High Risk for Progression to Severe Disease (*Last Reviewed and Updated 30 December 2021*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Molnupiravir	No Molnupiravir	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
COVID-19–related mortality (follow-up: range 28 days to 29 days)												
2 [257, 258]	randomized trials	not serious	not serious	not serious[a]	very serious[b,c]	none	1/764 (0.1%)	9/761 (1.2%)	**RR 0.11** (.01 to 0.86)	**11 fewer per 1000** (from 12 fewer to 2 fewer)	⊕⊕◯◯ LOW	CRITICAL
COVID-19–related hospitalizations (follow-up: 29 days)												
1 [257]	randomized trials	not serious	not serious	not serious[d,e]	very serious[c,f]	none	45/709 (6.3%)	64/699 (9.2%)	**RR 0.68** (.48 to 1.00)	**29 fewer per 1000** (from 48 fewer to 0 fewer)	⊕⊕◯◯ LOW	CRITICAL
Hospitalization or death (all-cause) (follow-up: 29 days)												
1 [257]	randomized trials	not serious	not serious	not serious[e]	very serious[b,c]	none	48/709 (6.8%)	68/699 (9.7%)	**HR 0.69** (.48 to 1.01)	**29 fewer per 1000** (from 49 fewer to 1 more)	⊕⊕◯◯ LOW	CRITICAL
Serious adverse events (follow-up: range 28 days to 29 days)												
2 [257, 258]	randomized trials	not serious	not serious	not serious	very serious[f,g]	none	6/765 (0.8%)	14/763 (1.8%)	**RR 0.43** (.17 to 1.11)	**10 fewer per 1000** (from 15 fewer to 2 more)	⊕⊕◯◯ LOW	CRITICAL

Certainty ratings are derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; HR, hazard ratio; ICU, intensive care unit; RR, risk ratio; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

[a]In Jayk Bernal et al [257], after day 29, 1 additional death resulting from adverse events occurred in the molnupiravir group and 3 additional deaths occurred in the placebo group. In Fischer 2021, at day 31, 1 additional death resulting from hypoxia occurred in the placebo group.

[b]Small number of events; fragility present.

[c]95% CI cannot exclude no meaningful benefit.

[d]COVID-19–related hospitalizations is a surrogate for ICU admission, mechanical ventilation, and death. Not rated down.

[e]All 10 patients reported as having died at day 29 had been hospitalized.

[f]Small number of events.

[g]95% CI cannot exclude the possibility of harms.

Table 38. GRADE Evidence Profile, Recommendation 31—Question: Colchicine Compared to No Colchicine for Hospitalized Patients With COVID-19 (*Last Reviewed and Updated 13 June 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Colchicine	No Colchicine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality												
10 [264–273]	randomized trials	not serious	not serious	not serious	serious[a]	none	1335/6684 (20.0%)	1385/6810 (20.3%)	**RR 0.99** (.92 to 1.06)	**2 fewer per 1000** (from 16 fewer to 12 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Mechanical ventilation												
5 [267–271]	randomized trials	not serious[b]	not serious	not serious	not serious	none	652/6242 (10.4%)	651/6370 (10.2%)	**RR 1.02** (.90 to 1.16)	**2 more per 1000** (from 10 fewer to 16 more)	⊕⊕⊕⊕ HIGH	CRITICAL
Length of hospital stay												
4 [264–266, 272]	randomized trials	serious[c]	serious[d]	not serious	serious[a,e]	none	134	132	…	**MD 1.77 d fewer** (3.69 fewer to 0.15 more)	⊕◯◯◯ VERY LOW	CRITICAL
Adverse events												
3 [271–273]	randomized trials	serious[c]	not serious	not serious	serious[e,f]	none	41/148 (27.7%)	20/151 (13.2%)	**RR 2.04** (1.07 to 3.91)	**138 more per 1000** (from 9 more to 385 more)	⊕⊕◯◯ LOW	IMPORTANT

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; RR, risk ratio.

[a]95% CI cannot exclude the potential for both meaningful benefit or harm.

[b]Largest trial was not blinded.

[c]Subjectively measured outcome with >50% of studies in analysis with unclear or unreported methods for randomization and lack of blinding.

[d]High heterogeneity: I^2 (97%). One study had an imbalance of patients receiving dexamethasone (23% vs 45% in intervention vs placebo arm) possibly contributing to shorter duration of hospitalization in the placebo arm.

[e]Few events suggest fragility of the estimate.

[f]95% CI cannot exclude the potential for no meaningful harm.

Table 39. GRADE Evidence Profile, Recommendation 32—Question: Colchicine Compared to No Colchicine for Ambulatory Persons With Mild-to-Moderate COVID-19 (*Last Reviewed and Updated 13 June 2022*)

Certainty Assessment							No. of Patients		Effect			
No. of Studies	Study Design	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Considerations	Colchicine	No Colchicine	Relative (95% CI)	Absolute (95% CI)	Certainty	Importance
Mortality												
3 [273–275]	randomized trials	not serious[a]	not serious	not serious	serious[b]	none	5/2431 (0.2%)	11/2426 (0.5%)	**RR 0.50** (.19 to 1.33)	**2 fewer per 1000** (from 4 fewer to 1 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Hospitalization												
2 [274, 275]	randomized trials	not serious[a]	not serious	not serious[c]	serious[d]	none	107/2391 (4.5%)	131/2386 (5.5%)	**RR 0.82** (.64 to 1.05)	**10 fewer per 1000** (from 20 fewer to 3 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Need for mechanical ventilation												
2 [274, 275]	randomized trials	not serious	not serious	not serious	serious[b]	none	10/2230 (0.4%)	20/2204 (0.9%)	**RR 0.50** (.24 to 1.07)	**5 fewer per 1000** (from 7 fewer to 1 more)	⊕⊕⊕◯ MODERATE	CRITICAL
Serious adverse events												
1 [274]	randomized trials	not serious	not serious	not serious	serious[b,e]	none	108/2195 (4.9%)	139/2217 (6.3%)	**RR 0.78** (.61 to 1.00)	**14 fewer per 1000** (from 24 fewer to 0 fewer)	⊕⊕⊕◯ MODERATE	CRITICAL

Certainty ratings may be derived from evidence that has not been peer reviewed or published. GRADE Working Group grades of evidence—High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Low certainty: Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. Very low certainty: We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect. Risk of bias: study limitations. Inconsistency: unexplained heterogeneity across study findings. Indirectness: applicability or generalizability to the research question. Imprecision: the confidence in the estimate of an effect to support a particular decision. Publication bias: selective publication of studies. Abbreviations: CI, confidence interval; COVID-19, coronavirus disease 2019; GRADE, Grading of Recommendations Assessment, Development, and Evaluation; ICU, intensive care unit; RR, risk ratio.

[a]Potential bias due to unclear or unreported details of randomization or deviations from intended interventions; however, low risk of bias for these domains within the study carrying the largest weight in the analysis and findings are not inconsistent.

[b]Few events suggest fragility of the estimate.

[c]Hospital admission is an intermediary outcome for morbidity, ICU admission, and need for ventilation. Not rated down.

[d]95% CI cannot exclude no meaningful benefit.

[e]95% CI cannot exclude no meaningful difference.

Table 40. Assessment of Clinical Severity of COVID-19 to Target Treatments

Severity of COVID-19
Mild-to-moderate COVID-19 (SpO_2 ≥94% on room air and not needing supplemental oxygen) with risk factors for progression to severe disease, hospitalization, or death[a]
Severe but not critical COVID-19 (SpO_2 <94% on room air or needing low-flow supplemental oxygen)
Critical COVID-19 needing high-flow oxygen or noninvasive ventilation
Critical COVID-19 needing mechanical ventilation or ECMO

Abbreviations: COVID-19, coronavirus disease 2019; ECMO, extracorporeal membrane oxygenation; SpO_2, oxygen saturation.

[a]A few of the risk factors are as follows: age >60 years, BMI >25 kg/m^2, diabetes, hypertension, cardiovascular disease, chronic lung disease, cancer, or immunocompromised patients. Risk factors for progression are changing as the epidemic evolves with new variants, vaccination, and previous infection rates.

Conclusions

The guideline panel suggests the use of molnupiravir for ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease who are within 5 days of symptom onset and have no other treatment options. More data are needed on the potential adverse effects of this medication. The evidence supporting this recommendation will be reassessed with the release of updated published information from the MOVe-OUT study and other trials (Tables 36 and 37).

Colchicine

Section last reviewed and updated 30 June 2022
Last literature search conducted 31 May 2022

Recommendation 31: In hospitalized patients with COVID-19, the IDSA panel recommends against colchicine for treatment of COVID-19. (strong recommendation, moderate certainty of evidence)

Recommendation 32: In ambulatory persons with COVID-19, the IDSA panel suggests against colchicine for treatment of COVID-19. (conditional recommendation††, moderate certainty of evidence)

††*The guideline panel concluded that the undesirable effects outweigh the desirable effects, although uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

Why Is Colchicine Considered for Treatment?

Colchicine has been used in various inflammatory conditions, such as gouty arthritis, pericarditis, and familial Mediterranean fever, for its anti-inflammatory properties. The anti-inflammatory mechanisms of colchicine are broad [259, 260] and include disruption of microtubules resulting in downregulation of proinflammatory cytokines [261, 262] and by reducing recruitment of inflammatory cells to endothelial cells [263]. Colchicine is widely available and relatively cheap, making it an attractive therapeutic to mitigate the

Table 41. Precautions With Therapeutic Agents Used in Treating COVID-19

Characteristic or Concern	Therapeutic Agents
Reduced eGFR/increased creatinine (specific cutoffs to be mentioned for each agent)	• Remdesivir—use with caution when CrCl <30 mL/minute • Baricitinib—dose adjustment when CrCl <60 mL/minute; not recommended for eGFR, 15 mL/minute • Tofacitinib—dose adjustment when CrCl <50 mL/minute • Nirmatrelvir/ritonavir—dose adjustment when eGFR <60 mL/minute; not recommended for eGFR <30 mL/minute
Increased AST or ALT (specific cutoffs to be mentioned for each agent)	• Baricitinib—discontinue if ALT or AST increases due to treatment • Remdesivir—consider discontinuation if ALT/AST increases to >10× the upper limit of normal • Tofacitinib—reduce dose for moderate hepatic impairment • Tocilizumab—may cause hepatic injury • Sarilumab—warning to avoid when ALT/AST are >1.5× ULN; discontinue if ALT/AST become 5× ULN during therapy
Cytopenias[a] (specific cutoffs to be mentioned for each agent)	• Tofacitinib—warning to avoid when lymphocytes <500 cells/mm^3, neutrophils <1000 cells/mm^3, or hemoglobin <9 g/dL • Baricitinib—warning to avoid when lymphocytes <500 cells/mm^3, neutrophils <1000 cells/mm^3, or hemoglobin <8 g/dL • Tocilizumab—associated with neutropenia and thrombocytopenia; warning to avoid for chronic use when ANC <2000 cells/mm^3 or platelets <100 000 per mm^3 • Sarilumab—associated with neutropenia and thrombocytopenia; warning to avoid for chronic use when ANC <2000 cells/mm^3 or platelets <150 000 per mm^3
Anti-rejection medications	• Nirmatrelvir/ritonavir significantly increases concentrations of tacrolimus, cyclosporine, and sirolimus. Dose modification or temporary discontinuation of these agents is required during concomitant use.
Age (pediatric and adolescent)[b]	• Molnupiravir is suggested for patients ≥18 years • Tocilizumab is suggested for patients ≥2 years • Sarilumab is suggested for patients ≥18 years • Baricitinib is suggested for patients ≥2 years • Tofacitinib is suggested for patients ≥2 years • Neutralizing antibodies are suggested for patients ≥12 years • Nirmatrelvir/ritonavir is suggested for patients ≥12 years

Table 41. Continued

Characteristic or Concern	Therapeutic Agents
	• Remdesivir is indicated for all ages • Dexamethasone is indicated for all ages
Reproductive concerns and pregnancy	• Molnupiravir is not recommended during pregnancy • Females: Advise individuals of childbearing potential to use a reliable method of contraception for the duration of treatment and for 4 days after the last dose of molnupiravir • Males: Advise sexually active individuals with partners of childbearing potential to use a reliable method of contraception during treatment and for at least 3 months after the last dose of molnupiravir

Abbreviations: ALT, alanine transaminase; ANC, absolute neutrophil count; AST, aspartate transaminase; COVID-19, coronavirus disease 2019; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate; ULN, upper limit of normal.

[a]Warnings come from chronic use of these medications for rheumatological disease. Patients with COVID-19 may have cytopenias, particularly lymphocytopenia, due to the viral infection. Using these agents in that situation may be indicated.

[b]Most pediatric data are derived from adult patients or other indications for these drugs.

inflammatory phase of COVID-19. This has resulted in numerous RCTs of colchicine in the management of COVID-19.

Summary of the Evidence

Our search identified 12 comparative RCTs in persons with COVID-19 treated with colchicine or an inactive comparison (eg, standard of care with or without placebo). Ten studies [264–273] informed the recommendations for hospitalized patients and reported on the outcomes of mortality, need for mechanical ventilation, length of hospital stay, and adverse events. The 3 studies [273–275] identified to inform the recommendation for ambulatory persons reported on the outcomes of mortality, hospitalization, need for mechanical ventilation, and serious adverse events.

Benefits

Hospitalized. In hospitalized patients, treatment with colchicine for COVID-19 rather than no colchicine failed to show or exclude a beneficial effect on mortality (RR: .99; 95% CI: .92, 1.06; moderate CoE). Treatment with colchicine rather than no colchicine for the purpose of COVID-19 does not reduce need for mechanical ventilation (RR: 1.02; 95% CI: .90, 1.16; high CoE). Hospitalized patients receiving colchicine experienced a trend toward reduced hospital stay (MD: −1.77 days; 95% CI: −3.69, .15 days; very low CoE); however, there are concerns about risk of bias, inconsistency, and imprecision.

Ambulatory. Treatment with colchicine likely does not reduce mortality or need for mechanical ventilation compared with

Table 42. COVID-19 Therapies by Disease Severity and Care Location

Care Location and COVID-19 Severity	Pharmacologic Treatments Available in the United States
Ambulatory mild-to-moderate disease (not hypoxemic) with high risk for progression to severe disease, hospitalization, or death (see individual drug section for specific considerations for each of these agents); can be considered in patients with mild–moderate COVID-19 hospitalized for other reasons	• Nirmatrelvir/ritonavir × 5 days (oral) • Remdesivir 3 days (intravenous) • Anti–SARS-CoV-2 monoclonal antibodies[a] • If other treatment options are not available, then consider molnupiravir × 5 days (oral) or, if immunocompromised, high-titer convalescent plasma with activity against circulating variant (intravenous) • Systemic steroids have no demonstrated benefit and may harm • No benefit demonstrated for hydroxychloroquine, azithromycin, lopinavir/ritonavir, or ivermectin
Hospitalized for mild-to-moderate COVID-19 (not hypoxemic)	• If at high risk for progression and within 7 days of symptom onset, remdesivir × 3 days • Systemic steroids have no demonstrated benefit and may harm • No benefit demonstrated in RCTs for convalescent plasma, hydroxychloroquine, azithromycin, lopinavir/ritonavir, or ivermectin
Hospitalized for severe, but not critical, COVID-19 (hypoxemic needing low-flow supplemental oxygen)	• Corticosteroids (dexamethasone 6 mg/day × 10 days or until discharge or an equivalent dose of another agent) • Remdesivir × 5 days • Tocilizumab or sarilumab in progressive disease with elevated inflammatory makers or • Baricitinib or tofacitinib in patients with elevated inflammatory markers • No benefit demonstrated in RCTs for convalescent plasma, hydroxychloroquine, azithromycin, lopinavir/ritonavir, or ivermectin
Hospitalized for critically ill COVID-19, needing noninvasive ventilation, or high-flow oxygen	• Corticosteroids (dexamethasone 6 mg/day × 10 days or until discharge or an equivalent dose of hydrocortisone or methylprednisolone) • Tocilizumab or sarilumab in patients with elevated inflammatory makers • Baricitinib or tofacitinib in patients with elevated inflammatory markers • No benefit demonstrated in RCTs for remdesivir, convalescent plasma, hydroxychloroquine, azithromycin, lopinavir/ritonavir, or ivermectin
Hospitalized for critically ill COVID-19, needing invasive mechanical ventilation or ECMO	• Corticosteroids (dexamethasone 6 mg/day × 10 days or until discharge or an equivalent dose of hydrocortisone or methylprednisolone) • Tocilizumab or sarilumab in patients with elevated inflammatory makers • Baricitinib or tofacitinib in patients with elevated inflammatory markers • No benefit demonstrated in RCTs

Table 42. Continued

Care Location and COVID-19 Severity	Pharmacologic Treatments Available in the United States
	for remdesivir, convalescent plasma, hydroxychloroquine, azithromycin, lopinavir/ritonavir, or ivermectin

Abbreviations: COVID-19, coronavirus disease 2019; ECMO, extracorporeal membrane oxygenation; RCT, randomized controlled trial; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

[a]Neutralizing antibodies that are active against prevalent variants should be utilized. For example, at present (04/2022) bebtelovimab has in vitro activity against Omicron BA.2 subvariant and should be utilized, but casirivimab/imdevimab, bamlanivimab/etesevimab, and sotrovimab do not have reliable activity against circulating Omicron BA.2 variant and should be avoided.

no colchicine among ambulatory persons with COVID-19 (RR: .50; 95% CI: .19, 1.33 [moderate CoE]; and RR: .50; 95% CI: .24, 1.07 [moderate CoE], respectively). The evidence failed to demonstrate a beneficial or detrimental effect on symptoms in hospitalization (RR: .82; 95% CI: .64, 1.05; moderate CoE).

Harms

Hospitalized. We were unable to exclude the potential for adverse events in hospitalized patients receiving treatment with colchicine rather than no colchicine for COVID-19 (RR: 2.04; 95% CI: 1.07, 3.91; low CoE).

Ambulatory. One study reported on serious adverse events among persons treated with colchicine rather than no colchicine for COVID-19. Serious adverse events may be less frequent among ambulatory persons receiving treatment with colchicine rather than no colchicine; however, this may not be meaningfully different from those not receiving colchicine (RR: .78; 95% CI: .61, 1.00; moderate CoE).

Other Considerations

The panel determined the CoE of treatment of colchicine for hospitalized patients to be moderate due to imprecision. The guideline panel made a strong recommendation against treatment of COVID-19 with colchicine for hospitalized patients with COVID-19.

The panel determined the CoE of treatment of colchicine for ambulatory persons to be moderate due to imprecision. The guideline panel made a conditional recommendation against treatment of COVID-19 with colchicine for ambulatory persons.

Conclusions and Research Needs for This Recommendation

The guideline panel recommends against colchicine for the treatment of hospitalized patients with COVID-19. The guideline panel suggests against colchicine for the treatment of ambulatory persons with COVID-19 (Tables 38 and 39).

HOW TO APPROACH A PATIENT WHEN CONSIDERING PHARMACOLOGIC TREATMENTS FOR COVID-19

In this section, we discuss how to approach a patient suspected to have COVID-19 and how to apply the IDSA COVID-19 treatment guidelines to specific clinical syndromes. The detailed evidence appraisals and recommendations for each therapeutic agent can be found in the individual sections. The certainty of supporting evidence is low to moderate for most recommendations; therefore, the guideline panel made conditional suggestions rather than strong recommendations for or against most of the agents. Although substantial progress was made with COVID-19 therapies in such a short period, there still remain many unanswered questions in the management of COVID-19. Therefore, the approach outlined here and in the guidelines are based on some assumptions and extrapolations. Despite limited evidence, to give actionable and timely guidance to frontline clinicians, we provide recommendations for use of combinations of agents, recommend some agents over others, or extrapolate to subpopulations not evaluated in trials.

Some of the critical unanswered questions in COVID-19 treatment trials are as follows:

- Which subpopulations or specific clinical types of patients with COVID-19 benefit most from specific therapeutic agents?
- What is the efficacy and safety of COVID-19 therapies in populations that are immune from prior SARS-CoV-2 infections and vaccination?
- What is the efficacy and safety of treatments in infections with specific SARS-CoV-2 variants and subvariants?
- How do therapeutic agents perform when compared with each other to allow a tiered approach to treating patients with COVID-19?
  - What is the comparative efficacy and safety of nirmatrelvir/ritonavir versus remdesivir, molnupiravir, and different anti–SARS-CoV-2 antibodies in mild-to-moderate disease?
  - What is the efficacy and safety of IL-6 inhibitors when compared with JAK inhibitors in severe disease?
- What is the comparative efficacy and safety of combinations of different drugs in treating different severities and clinical phenotypes of COVID-19?
- Which biomarkers can be used as predictors of therapeutic response to specific agents?

We hope future studies and trials address these uncertainties so we can give a more definitive treatment approach to COVID-19.

General Principles of COVID-19 Pharmacotherapy

During the early phase of the infection, when viral load is high and the host's adaptive immune system has not mounted an

adequate response, treatments targeting viral replication are most likely to be effective. These include both the direct antiviral therapies of nirmatrelvir/ritonavir, molnupiravir, and remdesivir and the passive immunity therapies of anti–SARS-CoV-2 antibodies and donor convalescent plasma. Timely initiation of antiviral therapies is critical as they are more efficacious when given within 5 to 7 days of symptom onset. Most patients do not progress to severe or critical disease, but some with risk factors do. Later in the disease process, in patients with severe and especially critical disease, an excessive and aberrant inflammatory response is implicated to be the primary cause of immunopathological damage. At this stage, anti-inflammatory therapies like corticosteroids, IL-6 inhibitors, or JAK inhibitors have been shown to be beneficial.

Clinical Evaluation

Clinical evaluation should consider patient- and pathogen-specific factors that can influence the choice of COVID-19 treatments. The evaluation should at least include assessment of the following:

- Severity of COVID-19
- Date of onset of symptoms
- Risk factors for progression to severe disease or death (see further discussion below, under Pharmacologic Treatment of Mild-to-Moderate COVID-19 With Risk Factors for Progression)
- Degree of chronic and acute end-organ dysfunction (including, but not limited to, pulmonary, cardiovascular, renal, and hepatic)
- Age and pregnancy status
- Virus-specific factors that may influence the choice of pharmacotherapy (eg, variant-specific susceptibility to certain drugs)
- Risk factors for progression are changing as the epidemic evolves with new variants, vaccination, and previous infection rates

Diagnostic classification of severity of COVID-19 helps target specific treatments to patient populations that have been demonstrated to benefit in COVID-19 treatment trials. The clinician should identify which of the severity categories in Table 40 the patient falls into.

It is also important to identify factors that preclude the use of COVID-19 treatments or warrant their use with caution. Patients with low eGFR were not included in the trials for remdesivir and tocilizumab. Elevated aspartate transaminase (AST) and alanine transaminase (ALT) levels are a contraindication for IL-6 inhibitors and remdesivir. Patients who were neutropenic; had an active bacterial, fungal, or parasitic infection; or were hypercoagulable were eliminated from some of the JAK inhibitor trials. It is also important to identify if the patients have other acute disease that either mimics COVID-19 or presents concomitantly with COVID-19. Patients can have a positive SARS-CoV-2 by RT-PCR from a nasopharyngeal sample, and present with pulmonary disease caused by a bacterial pneumonia or pulmonary edema. Patients with COVID-19 can also have pulmonary embolism contributing to their symptoms and hypoxemia. It is important to avoid anchoring bias to the diagnosis of COVID-19 and be attentive to considering and evaluating other etiologies. Many of the COVID-19 therapies are not FDA-approved and have instead received FDA EUA, so it is necessary to follow the regulatory processes and protocols for these agents (Tables 41 and 42).

Pharmacologic Treatment of Mild-to-Moderate COVID-19 With Risk Factors for Progression

COVID-19 is considered mild when there are clinical features suggestive of upper respiratory tract involvement without features of lung or other end-organ involvement. Moderate COVID-19 is pulmonary involvement with no hypoxia. Most patients improve with supportive care at this stage, but patients with risk factors can progress to more severe or critical disease or death; such individuals may benefit from pharmacotherapies. There are no validated clinical prediction rules or risk calculators, but the FDA EUA and CDC mention a few of these risk factors to consider for treatment with anti–SARS-CoV-2 antibodies [276]. More research is needed to identify prediction instruments and determinants that both increase or decrease the risk of severe disease and how potentially protective factors influence risk stratification. Most of these treatments are effective only when given early, within 5–7 days of symptom onset.

Patients who have these risk factors should be offered treatment with nirmatrelvir/ritonavir for 5 days (oral) or remdesivir for 3 days (intravenous). Parenteral anti–SARS-CoV-2 monoclonal antibodies can be used to treat, given that trials have shown a reduction in the need for hospitalizations, emergency room visits, or medically attended visits, but susceptibility to the prevalent variant should be considered in the choice of the monoclonal antibody. Bebtelovimab has in vitro activity against current circulating Omicron variants (04/2022), but casirivimab/imdevimab and bamlanivimab/etesevimab and sotrovimab do not have activity in laboratory studies. If other treatment options are not available then consider molnupiravir for 5 days (oral) or, if immunocompromised, high-titer convalescent plasma (intravenous) with activity against circulating variant. Convalescent plasma obtained from people who have recovered from COVID-19 due to Omicron and have been vaccinated is expected to be active against Omicron.

There are logistical issues related to the administration of parenteral agents in ambulatory settings, which may preclude their use. Oral antivirals like nirmatrelvir/ritonavir and molnupiravir have an advantage in that they are easy to prescribe in

outpatient settings, but there are significant limitations and unique considerations that need to be addressed by providers, which might be a barrier to their timely use. In the United States, many of the antiviral treatments do not have authorization for use in patients admitted to the hospital for mild-to-moderate COVID-19 but can be used if they are admitted for another reason and found to have mild-to-moderate COVID-19. We do not recommend using HCQ, AZ, or lopinavir/ritonavir, as trials have shown no evidence of benefit.

We recommend against the use of ivermectin outside of the context of a clinical trial, given the low CoE for its benefit. We also do not recommend the use of systemic corticosteroids in mild-to-moderate COVID-19. Although the RECOVERY trial was completed in hospitalized patients and not ambulatory patients, it demonstrated a trend to increased mortality when used in patients with mild-to-moderate COVID-19 (RR: 1.22; 95% CI: .86, 1.75) [100].

Pharmacologic Treatment of Severe CovID-19

Patients with severe COVID-19 are those whose infection has pulmonary involvement resulting in hypoxia while breathing room air and/or needing treatment with low-flow oxygen. Most existing criteria for trials consider either a SpO_2 level less than 94% or 90% or tachypnea (respiratory rate >30 breaths per minute) as severe COVID-19. Clinical judgment of individual cases should supplement these criteria.

Corticosteroids, especially dexamethasone, which has demonstrated a mortality benefit, are recommended as the cornerstone of therapy in severe COVID-19. Remdesivir may be considered as it has been shown to decrease time to recovery or discharge, although it has not been shown to improve mortality [32, 161].

The IL-6 inhibitors tocilizumab and sarilumab [108, 277] and JAK inhibitors baricitinib and tofacitinib [207] have shown a benefit in severe, but noncritical, COVID-19 when used with corticosteroids. The trials did not identify specific subpopulations of patients with severe COVID-19 already being treated with corticosteroids who would benefit most with additional treatment with IL-6 or JAK inhibitors. We recommend using either IL-6 inhibitors or JAK inhibitors (baricitinib preferred over tofacitinib) in those patients who have elevated inflammatory markers like CRP and progressive severe COVID-19. Since there are greater supportive data for tocilizumab and baricitinib we recommend them preferentially over sarilumab and tofacitinib, although the latter agents are suitable alternatives if the former are not available. We do not recommend using HCQ, AZ, lopinavir/ritonavir, or convalescent plasma as trials have not shown a benefit in patients with severe disease. We also recommend against the use of ivermectin outside of the context of a clinical trial, given the low CoE for its benefit.

Pharmacologic Treatment of Critically Ill Patients With COVID-19 Requiring Noninvasive Ventilation or Oxygen by High-Flow Nasal Cannula

Critically ill patients with COVID-19 need more ventilatory or oxygenation support either with high-flow oxygen or with noninvasive ventilation. High-flow oxygen therapy involves delivery of oxygen via special devices at rates greater than those possible via a simple nasal canula.

We strongly recommend systemic corticosteroids in critically ill patients with COVID-19 as they have shown a mortality benefit in this population (OR: .66; 95% CI: .54; 0.82) [79]. In critically ill patients, dexamethasone 6 mg/day is preferred, but doses up to 20 mg/day can be used if indicated for other reasons. Hydrocortisone 50 mg IV every 6 hours is an alternative that has also been studied. Methylprednisolone and prednisone have fewer supporting data but are reasonable pharmacologic alternatives at equipotent doses. In addition to corticosteroids, we recommend using either IL-6 inhibitors (tocilizumab preferred over sarilumab) or JAK inhibitors (baricitinib preferred over tofacitinib) in patients who have elevated inflammatory markers (eg, CRP), which most critically ill patients with COVID-19 have. The trials done so far have not identified specific subpopulations of critically ill patients already being treated with corticosteroids who would benefit with additional treatment with IL-6 or JAK inhibitors. We do not recommend remdesivir since it has not shown a benefit in this subpopulation [161].

Pharmacologic Treatment of Critically Ill Patients With CovID-19 Needing Invasive Mechanical Ventilation or ECMO

Patients who are critically ill with COVID-19 pulmonary disease and dysfunction needing significant ventilatory support with invasive mechanical ventilation or ECMO have the highest risk of mortality. Pharmacologically, we recommend treating them similarly to those on noninvasive ventilation or high-flow nasal cannula. Corticosteroids are strongly recommended in this category of critically ill patients as trials have demonstrated a mortality benefit [79]. In addition to steroids, the panel recommends using either IL-6 inhibitors (tocilizumab is preferred over sarilumab) in critically ill patients who have elevated inflammatory markers like CRP. In situations where IL-6 inhibitors are not available, baricitinib can be used in mechanically ventilated patients, as a small trial showed a mortality benefit in this population [278]. Most other COVID-19 therapies studied in other severities have either not demonstrated benefit or have not been studied in this population.

BACTERIAL COINFECTIONS AND ANTIBIOTIC USE

Patients with COVID-19 often present with viral pneumonia with accompanying febrile illness and respiratory symptoms. Differential diagnoses may include bacterial pneumonia, for which antibiotics are prescribed. Concerns also exist for bacterial superinfections in hospitalized patients during the course

of illness. Studies reported to date mainly describe antibiotic use during the early phase of the COVID-19 pandemic and consistently report high percentages of antibiotic use worldwide (58–95%) [1, 279–285]. One registry of 150 Spanish hospitals found that over 75% of patients received antibiotics, but diagnosis in the early months of the pandemic was a predictor of inappropriate antibiotic use. Antibiotic use was associated with adverse drug reactions [286].

Table 43. Case Definitions for Multisystem Inflammatory Syndrome in Children (MIS-C) and Pediatric Inflammatory Multisystem Syndrome Temporally Associated With COVID-19 [pediatric Inflammatory Multisystem Syndrome: Temporally Associated with SARS-CoV-2 (PIMS-TS)]

	MIS-C (CDC 2020) [360]	PIMS-TC or PMIS (Royal College of Paediatrics and Child Health 2020) [361]
Includes	Age <21 years presenting with: • Fever (>38.0°C for ≥24 hours, or report of subjective fever lasting ≥24 hours) • Laboratory evidence of inflammation (including, but not limited to, 1 or more of the following: an elevated CRP, erythrocyte sedimentation rate, fibrinogen, procalcitonin, D-dimer, ferritin, lactic acid dehydrogenase, or interleukin-6, elevated neutrophils, reduced lymphocytes, and low albumin) • Evidence of clinically severe illness requiring hospitalization, with multisystem (>2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, or neurological)	A child presenting with: • Persistent fever >38.5°C • Laboratory evidence of inflammation (neutrophilia, elevated CRP, and lymphopenia) • Evidence of single or multiorgan dysfunction (shock, cardiac, respiratory, renal, gastrointestinal, or neurological disorder) with additional features (listed in Appendix of reference [361])
Excludes	Patients with alternative plausible diagnoses	Patients with any other microbial cause, including bacterial sepsis, staphylococcal or streptococcal shock syndromes, infections associated with myocarditis such as enterovirus
Other criteria	Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test; or COVID-19 exposure within the 4 weeks prior to the onset of symptoms	SARS-CoV-2 PCR testing may be positive or negative

Abbreviations: CDC, Centers for Disease Control and Prevention; COVID-19, coronavirus disease 2019; CRP, C-reactive protein; PCR, polymerase chain reaction; RT-PCR, reverse transcriptase–polymerase chain reaction; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

Data reporting coinfection in patients presenting with COVID-19 for care have mostly focused on patients receiving care in hospitals. As more studies have become available, they can be grouped into those describing coinfection at the diagnosis of COVID-19, those describing the treatment of superinfections during the course of COVID-19 infection, those that report both, and those that do not distinguish between these types of infections. The latter are not discussed here.

Despite the majority of patients with COVID-19 being treated with antibiotics on admission early in the pandemic, existing studies have found bacterial coinfections to be uncommon. Vaughn and colleagues [283] evaluated a random cohort of patients with COVID-19 across 38 hospitals in Michigan. Of the 1705 patients included, only 3.5% had a bacterial coinfection, although 59.5% received antibacterial drugs. A cohort of 1016 patients with COVID-19 across 5 Maryland hospitals found bacterial coinfection in only 1.2% [287]. A meta-analysis including 3338 patients in 24 studies reported bacterial coinfection in 3.5% [288]. Smaller studies had congruent reports, ranging from 3.1% to 4% [289–291]. A study of 64 961 patients with COVID-19 in the Premier Healthcare Database is an outlier, reporting bacterial coinfections in 18.5% of infections between April and June 2020, but this relied on International Classification of Diseases, 10th Revision (ICD-10), codes and not microbiological diagnoses. Urinary tract infections were most reported [292].

Studies describing superinfections that developed in patients with COVID-19 are more heterogeneous. Studies that describe the incidence of superinfection in entire hospitalized cohorts of COVID-19 report incidences of superinfection of 4.2% to 21% [288, 291, 293]. Small studies of patients requiring mechanical ventilation and with COVID-19–associated ARDS reported superinfections in 44.4% and 27.7% of patients, respectively [294, 295].

The apparent discordance between bacterial and fungal coinfection in patients with COVID-19 at presentation and the use of antibacterial therapy has potential negative effects, namely in antimicrobial resistance. Several studies have attempted to differentiate patients with and without concomitant bacterial infections using laboratory data. The use of procalcitonin in a group of hospitals was not effective as a tool to encourage antibiotic discontinuation compared with clinical judgment [296]. Mason and colleagues [284] compared hospitalized cohorts of 619 patients with COVID-19 and 106 with community-acquired bacterial pneumonia (CABP) to determine if inflammatory markers could be used to rule out bacterial coinfection [297]. They found marked differences in white blood cell counts between groups (6.78 COVID-19 × 106 cells/mL vs 12.48 CABP × 106 cells/mL), and that CRP declined in 48–72 hours with antibiotic therapy in the CABP cohort but not the COVID-19 group, suggesting that these can be used to guide antibiotic discontinuation when initiated empirically

in patients with COVID-19. Initiating and continuing empiric antibiotics at the time of admission may lead to superinfections that are antibiotic resistant; 1 study found antibiotic use in the first 2 days of admission for COVID-19 to be a risk factor for superinfection [293]. Immunomodulatory therapies are recommended for many patients with severe and critical illness from COVID-19, including corticosteroids, IL-6 antagonists, JAK inhibitors, and others [298]. Most of the prospective studies that support these recommendations have not reported higher rates of infection in patients receiving immunomodulators, but follow-up is limited in most cases and late infections may be missed.

PEDIATRIC CONSIDERATIONS FOR TREATMENT OF SARS-CoV-2 INFECTION AND MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN

Acute SARS-CoV-2 Infection in Children

Clinical Presentation

Case [299, 300] and hospitalization [301] rates from SARS-CoV-2 infection in children are lower than in adults, and asymptomatic infection is more common [302, 303]. However, infection can lead to significant illness and even death in children [304–306]. Clinical presentations of infection can be nonspecific and may more frequently include fever alone and/or gastrointestinal symptoms [307] than in adults. Children are also capable of transmitting disease to others [308].

Factors that lead to severe illness in children with SARS-CoV-2 infection are less well defined than in adults. Comorbidities including medically complex conditions (including certain genetic disorders, neurologic diseases, and cancer) [309], type 1 diabetes, complex congenital heart disease, and obesity have all been associated with a higher risk of hospitalization and ICU admission in children [306, 310–312].

Management

Remdesivir

The studies involving the use of remdesivir in hospitalized patients with COVID-19 (**Recommendations 15–17**) [32, 161–163, 313] have generally focused on individuals over age 18 years. Two trials included children over 12 years [163, 313] but did not separately report the number or outcomes (including adverse events) of participants under 18 years. Nevertheless, remdesivir is commonly used and recommended by expert panels [314] of pediatric infectious disease specialists in hospitalized children with SARS-CoV-2 infection, and reports suggest low adverse event rates [164, 315]. An ongoing phase II/III open-label study in children (the "CARAVAN" trial) [165] has not yet reported their results in the peer-reviewed literature [316]. Recent studies of outpatient remdesivir treatment in individuals at high risk for progression support its use in pediatric patients down to 3.5 kg of body weight.

Corticosteroids

Dexamethasone and other corticosteroids are recommended in certain hospitalized patients with COVID-19 (**Recommendations 7–9**). The studies informing these recommendations [79, 100] either did not include children or did not separately report the number or outcomes (including adverse events) of participants under 18 [100] years. Corticosteroid use is nevertheless common in hospitalized children with COVID-19 [311], and there is reason to believe that the risk–benefit ratio would be similar in children and adults.

IL-6 Blockade

Tocilizumab or sarilumab is suggested for use in treatment of COVID-19 in certain situations (**Recommendations 11** and **12**). Of the studies informing the recommendations for tocilizumab [107, 108, 110–113, 317, 318], only 2 [107, 108] did not specifically exclude children under 18 years from enrolling. The RECOVERY trial included children, but results from those in the tocilizumab arm of the trial have not yet been reported. Hermine et al [107] did not specifically exclude children, but results in children were not separately reported either.

Three of the 4 studies used to inform the recommendations for sarilumab excluded children from participation [114, 115, 317]. The preprint network meta-analysis of 18 RCTs of IL-6 inhibitors included some studies that enrolled children, but results in children were not separately reported.

There are several publications reporting on cohorts of children with COVID-19 who received treatment with tocilizumab [315, 319–321]. Although there have been no clear contraindications to using IL-6 inhibitors in children based on these reports, more studies in children are needed to determine whether the criteria for their pediatric use would be similar to those in adults.

JAK Inhibitors

Baricitinib is suggested for use in treating certain hospitalized patients with COVID-19 (**Recommendations 23 and 24**). However, the studies that inform these recommendations did not include children [201, 206, 207, 278]. Although the EUA for use of baricitinib in treatment of COVID-19 extends to children over 2 years of age [322], baricitinib does not have an FDA indication for treatment of other conditions in children, and there are only limited published pediatric pharmacokinetic data [323]. A pediatric safety and pharmacokinetic study on baricitinib use in children with COVID-19 is now recruiting [324].

Tofacitinib is also suggested for use in treating certain hospitalized patients with COVID-19 (**Recommendation 25**). As with baricitinib, the trial informing this recommendation did not include children [210]. Tofacitinib is used in children

over age 2 and over 10 kg for treatment of polyarticular juvenile idiopathic arthritis when they have had an inadequate response or intolerance to 1 or more tumor necrosis factor inhibitors [325]. There are no currently open trials studying tofacitinib for treatment of COVID-19 in children.

Oral Antivirals

Two new antiviral agents have been issued an EUA and include nirmatrelvir/ritonavir and molnupiravir. Nirmatrelvir/ritonavir is not authorized in children younger than 12 years of age and weighing less than 40 kg [326]. However, there have been no safety or effectiveness studies in pediatric patients. Molnupiravir is not recommended for use in children due to animal studies that suggest effects on bone and cartilage growth.

Monoclonal Antibodies

Neutralizing monoclonal antibodies directed against the spike protein of SARS-CoV-2 are suggested for use in prophylaxis and treatment of individuals exposed to or infected with SARS-CoV-2 who are at high risk of progression to severe disease (**Recommendations 20** and **21** and **Recommendation 22**, respectively). Careful attention should be paid to the activity of the different available monoclonal antibodies against circulating variants at the time their use is considered. Bebtelovimab is the only monoclonal antibody with activity against current circulating Omicron variants. Pediatric-specific data on bebtelovimab have not yet been published, although it is reasonable to expect a similar risk–benefit ratio as for other SARS-CoV-2 monoclonal antibodies.

In terms of activity against earlier variants, the study informing the recommendations for prophylactic use of casirivimab/imdevimab (**Recommendation 21**) included children over 12 years of age [175]. Among the 752 participants randomized to placebo and the 753 participants randomized to casirivimab/imdevimab, there were 34 in each group between the ages of 12 and 18 years. Four placebo recipients and no casirivimab/imdevimab recipients experienced a symptomatic PCR-confirmed SARS-CoV-2 infection during the study (OR: 0.17; range: 0.00–1.07). Adverse effect data were not separately reported for children but were generally mild.

Use of bamlanivimab/etesevimab for prevention of progression to severe disease in ambulatory individuals with mild-to-moderate disease (**Recommendation 22**) was supported based on a study that included children over age 12 years [182]. Among a total of 517 participants randomized to placebo and 518 to bamlanivimab/etesevimab, 7 and 4 participants, respectively, were between 12 and 18 years old. Data on outcomes or adverse events were not separately reported for children in this study but bamlanivimab/etesevimab was generally well tolerated. An ongoing study of bamlanivimab/etesevimab, including in a pediatric expansion of the BLAZE-1 trial, allowed evaluation of pharmacokinetics and safety of bamlanivimab/etesevimab in 125 total pediatric participants. This led to an expanded FDA authorization [327] for this antibody combination in treatment of mild-to-moderate COVID-19 in children who are at high risk of progression to severe disease, including neonates, and in PEP of COVID-19 in children who are at high risk for progression to severe COVID-19 and not fully vaccinated or not expected to mount an adequate immune response to complete SARS-CoV-2 vaccination.

The recommendation for use of casirivimab/imdevimab for prevention of progression to severe disease in ambulatory individuals with mild-to-moderate disease (**Recommendation 22**) was based on a study that included a cohort of participants under age 18 years [328]. The portion of the trial including children is ongoing, with no pediatric data on outcomes or adverse events reported to date.

The inclusion of sotrovimab in the recommendation for prevention of progression to severe disease in ambulatory individuals with mild-to-moderate disease (**Recommendation 22**) was based on a trial that included only participants over age 18 years [329], with no pediatric-specific data available. This monoclonal antibody is not sufficiently active against currently circulating Omicron variants (04/2022).

There have been several multicenter studies of casirivimab/imdevimab [330–333], bamlanivimab/etesevimab [334], or sotrovimab [335, 336] for treatment and prevention of SARS-CoV-2 disease in different pediatric populations, including those under 12 years. These studies are complicated by the predominance of the Omicron strains.

As noted above, the FDA has defined specific conditions for EUA use of monoclonal antibody therapies for SARS-CoV-2 infection (Figure 4), although risk factors for progression to severe illness in children are less well defined than in adults. The relative absence of pediatric-specific data has led a panel of pediatric infectious disease specialists to recommend routine use of these treatments only in children thought to have a high risk for progression to severe disease [337].

Treatments Not Recommended for Use

As noted in other sections of this document, several interventions have been tested in adult populations and not found to have clinical benefit. This has led to recommendations against the routine use of HCQ, lopinavir/ritonavir, inpatient convalescent plasma, and famotidine. Although the studies informing these recommendations largely excluded children with acute infection, the experience in adult patients suggests that these drugs would not be expected to have benefit in treatment of children with similar disease characteristics.

Multisystem Inflammatory Syndrome in Children

Clinical Presentation

Multisystem inflammatory syndrome in children (MIS-C), also called pediatric inflammatory multisystem syndrome

temporally associated with COVID-19 [pediatric Inflammatory Multisystem Syndrome: Temporally Associated with SARS-CoV-2 (PIMS-TS)], is a rare acute inflammatory syndrome reported in children several weeks following acute SARS-CoV-2 infection. Case definitions for this syndrome were derived after reports of critically ill children presenting with fever, rash, conjunctivitis, abdominal complaints, shock, and significant cardiac dysfunction in the setting of recent SARS-CoV-2 infection [338–350] (Table 43). The incidence of MIS-C is higher in Black, Hispanic or Latinx, and Asian or Pacific Islander children than in White children and most common among children between 6 and 10 years of age [351, 352]. Epidemiologic data showing clusters of MIS-C cases following peaks of positive SARS-CoV-2 test rates by 2–5 weeks [353] support that the syndrome results from a delayed immunologic response to the infection.

Management

Once the diagnosis of MIS-C has been made, immunomodulatory medications are the mainstay of therapy. Although trials are lacking to demonstrate the superiority of any given approach, IV immunoglobulin (IVIG) and systemic steroids are frequent initial choices [347, 354]. Studies comparing outcomes after initial treatment using IVIG alone, steroids alone, or a combination of IVIG and steroids have come to differing conclusions on their relative importance in treatment. The combination of both has been reported to lead to faster and more sustained resolution of fever than IVIG alone [355]. Biologic treatments including anakinra, infliximab, or tocilizumab have also been used in refractory cases [354, 356–358], although data are limited to inform the choice among these interventions or those patients who would benefit most. Despite these limitations, overall outcomes of children with MIS-C have been generally good, with few fatalities reported [350, 359].

Supplementary Data

Supplementary materials are available at *Clinical Infectious Diseases* online. Consisting of data provided by the authors to benefit the reader, the posted materials are not copyedited and are the sole responsibility of the authors, so questions or comments should be addressed to the corresponding author.

Notes

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