FOR MD · DO · NP · PA

PAXLOVID IN NURSING HOMES

Prescribe with confidence—a pocket reference for SNF / LTC providers.

ELIGIBILITY

- Symptoms ≤ 5 days (counting from symptom onset, not test)
- Age ≥ 50, or ≥1 high-risk condition*
- Confirmed COVID-19 (antigen or PCR)
- Not hypoxic / not requiring hospital transfer

In a nursing home, almost every resident with COVID-19 qualifies for antiviral treatment

***ADDITIONAL FACTORS THAT RISK MORE SEVERE DISEASE, AND ADD TO THE POTENTIAL BENEFIT FROM ANTIVIRAL:**

- Lung, heart, or kidney problem: yes
- Diabetes: yes
- Dementia, frailty, or disability: yes
- BMI >25 : yes
- Current or former smoker: yes

2. RENAL DOSING — CHECK eGFR BEFORE PRESCRIBING

eGFR (mL/min)	Dose (for 5 days)	Note
≥ 60	Nirmatrelvir 300 mg + ritonavir 100 mg twice daily	Standard
30 TO < 60	Nirmatrelvir 150 mg + ritonavir 100 mg twice daily	Reduced, most common LTC scenario
< 30	Nirmatrelvir 300 mg + ritonavir 100 mg on day 1 and then nirmatrelvir 150 mg + ritonavir 100 mg once daily	Reduced Dose

A creatinine within the last 6 months is acceptable in a stable resident. **Do not delay treatment for "fresh" labs unless AKI is suspected.**

3. THE MOST COMMON DRUG INTERACTIONS YOU'LL ENCOUNTER IN NURSING HOME

HOLD **ATORVASTATIN, SIMVASTATIN,**	Hold for 5 days of treatment + 2 days after. Resume the same dose. Pravastatin and rosuvastatin (≤ 10 mg) are safer alternatives if a substitute is needed.
SWITCH / MONITOR **APIXABAN, RIVAROXABAN**	Levels rise. Apixaban: reduce to 2.5 mg twice daily during treatment. Rivaroxaban: avoid concurrent use; bridge with LMWH if anticoagulation is essential.
MONITOR **WARFARIN**	INR can shift in either direction. Check INR on day 3 and at 1 week post.
CONTRAINDICATED **AMIODARONE, DRONEDARONE, FLECAINIDE**	Do not co-administer. Most NH residents on these have safer alternatives — or accept brief rate-only management. Cardiology curbside if unsure.
REDUCE **CCBS (AMLODIPINE, DILTI-AZEM)**	Levels rise — watch for hypotension, bradycardia. Consider 50% dose reduction; check BP daily during treatment.
CONTRAINDICATED **CARBAMAZEPINE, PHENYTOIN, RIFAMPIN, ST. JOHN'S WORT**	Strong inducers — render Paxlovid sub-therapeutic. Defer or use alternative antiviral.

Default mindset: Most LTC interactions are manageable, not absolute. The Liverpool COVID-19 DDI checker gives a same-day answer. Don't let polypharmacy alone be a reason to withhold treatment in a high-risk resident.

4. HOW TO ORDER IN A SNF

SAMPLE ORDER

Nirmatrelvir/ritonavir 300 mg / 100 mg PO BID x 5 days

(or 150 mg / 100 mg BID if eGFR 30–59)

Start: TODAY. Hold atorvastatin x 7 days.

→ Confirm eGFR and med list with pharmacy

→ Use facility standing order set if available

→ Document day of symptom onset in note

→ STAT pharmacy if first dose not on-site

5. COMMON HESITATIONS

"THE RESIDENT HAS ONLY 3 DAYS OF SYMPTOMS, TOO EARLY?"

No. Earlier is better. Day 1–3 is the highest-yield window. Don't wait.

"SYMPTOMS ARE MILD, REALLY NEED TREATMENT?"

Treat anyway in frail/older residents. Mild on day 2 doesn't predict mild on day 7.

"RESIDENT IS ON 12 MEDICATIONS. TOO RISKY?"

Polypharmacy alone is not a contraindication. Run the DDI list; usually 1–2 meds need to be held briefly. Consult with your pharmacy

"DAY 5, LATE IN THE DAY, STILL TREAT?"

Yes — start tonight, not tomorrow. Day 5 is in-window. Day 6 is not.