MINISTRY OF HEALTH
SINGAPORE

MH 34:24/8 MOH Circular No. 50/2023

31 July 2023

See Distribution List

UPDATES ON COVID-19 POLICY AND GUIDELINES FOR DORSCON GREEN

This Circular provides the latest updates for the management of COVID-19 patients by healthcare providers and MOH case reporting requirements **with effect from 13 Aug 2023**.

a. Cessation of referral of high/intermediate risk COVID-19 positive patients for fully subsidised 24/7 ad-hoc Telemedicine (TM) services. (Details in **Figure 1**, **Para 6**, and **Annex E**)

b. Extension of OAV age eligibility to 50-59 years old. (Details in **Para 5**)

c. Removal of notification to Forensic Medicine Division for COVID-19 Deceased. (Details in **Para 11**)

d. Cessation of MOH recovery certificate issuance. (Details in **Para 15**)

2. The above changes are incorporated into this circular which will supersede MOH Circulars No. 04/2023 and 04A/2023.

Management of COVID-19 Patients

3. **Testing Advice**. SARS-CoV-2 testing is no longer routinely required for every patient with acute respiratory infection (ARI) symptoms, although doctors-in-charge can choose to do so as part of the diagnostic workup.

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a. **Antigen Rapid Test (ART) as default**. If testing is clinically indicated, the default choice should be the ART. For healthcare provider-administered ARTs, healthcare providers should communicate the results to patients in alignment with other point of care testing.

b. **Patients who are medically vulnerable**. Testing of patients with ARI symptoms is strongly recommended for patients who are medically vulnerable and would benefit from early COVID-19 diagnosis and treatment (i.e., paediatric, pregnant, geriatric, dialysis-dependent and immunocompromised patients). If the ART is negative, an additional PCR test should be considered, especially if clinical suspicion is high, as the PCR is a more accurate test.

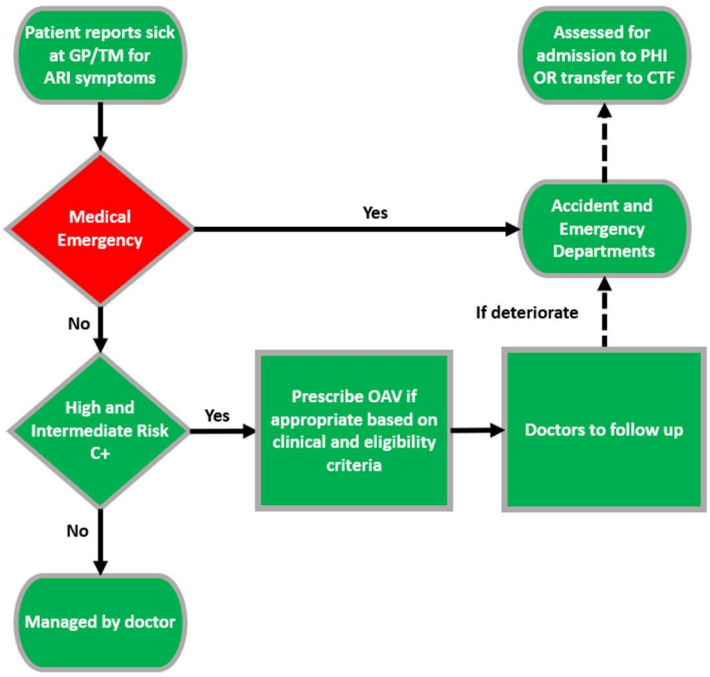
c. **PCR testing may also be offered to patients** if the clinic is participating in the ARI sentinel surveillance programme.[1]

d. **Patients with travel history** in the 7 days prior to the onset of ARI symptoms are still recommended to be tested. This contributes to MOH's continued surveillance of the global COVID-19 situation.

4. **Patient Management in the Community (Revised)[2].** Doctors-in-charge[3] should generally manage patients with ARI symptoms and/or COVID-19 positive patients in the community, and only escalate clinically unstable patients to Accident and Emergency Departments (A&E). The risk criteria for the adult, paediatric and pregnant patients have been updated to reflect prevailing disease severity rates, given the current population vaccination profiles **(Annex A)**. Where clinically indicated, doctors-in-charge should also **perform ART, prescribe oral anti-virals (OAVs)** and provide return advice and/or schedule follow-up consultations **(Figure 1)**.

[1] ARI Sentinel Surveillance testing is carried out at polyclinics and will be expanded to include some GP clinics. ARI Sentinel Surveillance would require a PCR test.
[2] For patients with ARI symptoms and/or COVID-19 positive patients in Nursing Homes and MSF Homes, Recovery-in-situ (RIS) should be the default option where possible.
[3] Doctors-in-charge refers to registered medical practitioners who provide clinical care for persons with health concerns as well as continual care for known medical conditions. This includes General Practitioners (GPs), Polyclinic doctors and Specialist doctors who are involved in patient care and management.

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NOTE:
Doctors-in-charge should do the following:
1. Manage the vast majority of COVID-19 positive patients, and escalate to A&E departments only if required (i.e. acutely unwell or deteriorating)
2. Exercise clinical judgement and perform testing (if clinically indicated), and provide return advice/follow up as required (mandatory for OAV prescription). PCR can be added based on clinical discretion as it is a more sensitive test.

Figure 1. Patient Care Model from 13 Aug 2023.
For conveyance from a PHI inpatient ward/ED to a CTF, PHIs should follow existing decant workflows and email CMData@moh.gov.sg to submit requests for transfer to a facility using the standard decant template, or leverage existing structured communication platforms between PHIs and the assigned facility for in-pro, with arrangement of CMTG conveyance through contact at 6435 4060.

5. **Extension of OAV Age Eligibility**. Paxlovid may be considered for persons aged 50-59 years, regardless of vaccine status. Molnupiravir is not recommended for persons in this age group unless other risk factors are present. (See **Annex B** for updated Checklist)

6. **Cessation of free 24/7 Ad-hoc Telemedicine (TM) services**. The free 24/7 ad-hoc TM support for referred high/intermediate risk patients will cease from 13 Aug 2023. Doctors-in-charge can still follow up with their own patients using TM, if needed. Patients who require TM services may also select their preferred TM providers using resources on "*FluGoWhere"* website (https://flu.gowhere.gov.sg/). In both cases, these services are chargeable.[4] For patients who require OAVs, clinics that provide OAVs are indicated on the "*FluGoWhere"* website (https://flu.gowhere.gov.sg/).

7. **COVID-19 Positive Paediatric patients (including neonates)**. Neonates (less than 1 month old) and infants younger than three months can be managed in the community by primary care physicians.[5] However, COVID-19 positive neonates **with fever (≥38°C) should continue to be referred** to the Children's Emergency (CE) for clinical assessment and considered for admission to conduct inpatient

[4] In-line with charging policies for COVID-19 related treatment today.
[5] SD Biosensor Standard Q is now approved for use in children below 2 years old and be administered by healthcare workers. This is in addition to Abbott Panbio COVID-19 Antigen Self-Test and ACON Biotech Flowflex SARS-COV2 Antigen Rapid Test (Self-testing).

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investigations/ management. Children with comorbidities (**Annex A, Figure A-2**) and infants less than 3 months old[6], should be co-managed with their paediatricians. Those without an attending paediatrician, are advised to consult one for additional medical support and expertise (please visit ***https://flu.gowhere.gov.sg/*** for the list of paediatricians), as they are more at risk of developing more severe illness. Doctors-in-charge are to have a high index of suspicion for Multi-system Inflammatory Syndrome in Children (MIS-C) when managing patients below 19 years old.

Submission of COVID-19 Results for Case Reporting

8. **COVID-19 tagging and submission of COVID-19 test results**. Please be reminded that notification and tagging of COVID-19 positive patients should be done using the following modes and not through Communicable Diseases Live & Enhanced Surveillance (CDLENS).

a. **PRPP, iConnect and SRS** users should continue to submit COVID-19 positive test results through these platforms.

b. **EMR** users to submit COVID-19 positive test results via EMR, and FormSG by using the embedded link in EMR **or via *https://go.gov.sg/submit-covid-tagging*** (see **Annex C** for details).

9. ART results submitted via PRPP/ iConnect/ SRS/ EMR will be reflected in HealthHub. PCR results will continue to be automatically updated in HealthHub.

10. **Supervised ART Swabs**. This procedure will be allowed for all age groups (i.e., beyond the currently approved group of paediatric patients) across all healthcare settings (including public/private/community hospitals, nursing homes, and renal dialysis centres, if applicable). While healthcare administered swabs should be the default modality to ensure consistency and quality control to guide subsequent clinical management of the patient, supervised in-person swabbing is permissible. Unsupervised self-administered ARTs will not be accepted for the submission of COVID-19 test results.

11. **Notification of deaths and management of deceased persons due to COVID-19**. MOH do not need to be notified of deaths due to COVID-19. There is also no need to notify Forensic Medicine Division (FMD) if the COVID-19 deceased is to be transferred to FMD under the Coroner's Act.

[6] Doctors-in-charge should screen these patients for comorbidities.

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12. A copy of the "***Memo by Medical Practitioner for Personnel Managing Deceased Persons with Suspected or Confirmed COVID-19***" should continue to be provided to the family of COVID-19 deceased. The memo is provided in **Annex D**. The family of the deceased should be informed to provide the memo to the engaged undertaker, to facilitate the safe handling and management of the deceased's remains.

Submission of COVID-19 Vaccination Records

13. Medical practitioners who carry out or supervise the carrying out of a COVID-19 vaccination must continue to notify to the National Immunisation Registry within 72 hours of vaccination the following details:[7]

a. Name and identification document number of the person vaccinated
b. Brand of COVID-19 vaccine
c. Batch/lot numbers
d. Date of vaccine administration

COVID-19 Recovery in the Community

14. **General advisory**. Persons with mild ARI symptoms and/or **COVID-19 positive patients who are mildly ill should be advised to recover at home with appropriate infection prevention control measures**. If there is a need to leave home while symptomatic, they should wear a mask, minimise social interactions, avoid crowded places and vulnerable settings such as hospitals and nursing homes, and avoid contact with vulnerable persons such as the elderly.

15. **Medical certificates (MCs) and Memos**. Doctors-in-charge are recommended to exercise their clinical judgement when issuing the duration of sick leave for COVID-19 positive patients and/or patients with ARI symptoms and can adjust the duration as appropriate. Patients should be advised to seek medical attention if their symptoms worsen or do not improve with time. The provision of MOH recovery certificates will cease from 13 Aug 2023. Doctors-in-charge should issue memos for patients who require documentation of COVID-19 infection. Alternatively, patients who are tagged could visit the website www.notarise.gov.sg/ to generate their notarised recovery certificates.

16. **Accommodation for recovery**. If there are vulnerable members in the same household (for example, 80 years old and above who are unvaccinated or not fully vaccinated), COVID-19 positive patients should be advised to take preventive measures to mitigate infection spread, such as wearing a mask, cleaning the toilet

[7] The notification of COVID19 vaccination continues to be legal requirement under the Infectious Disease (COVID-19 Vaccination) Regulations.

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after every use, and not sharing a room with other household members. If patients are unable to exercise preventive measures and are concerned about the well-being of their vulnerable household members, **these patients might consider alternative accommodation arrangements, other than their residence**. Should patients express difficulty in arranging for alternative accommodation and require lodging, MOH may assist patients on a case-by-case basis such as admitting them to Community Isolation Facilities (CIF)[8] and doctors-in-charge should advise these patients to contact the 24-hourly manned MOH HRB hotline at **68744939**. This provision will be reviewed with the proposal to stand down all COVID-19 operations.

17. **Commuting**. Commuting on public transport services, such as bus and MRT, is permitted for COVID-19 positive patients. Patients are to make their own transport arrangements when conveyancing between places of residences (including nursing/MSF homes) and health care facilities (e.g., PHIs, Renal Dialysis Centres, clinics), as well as when discharging from facilities.[9] **All COVID-19 positive patients and/or patients with ARI symptoms should remain masked regardless of transportation modality**. In the event of a medical emergency, SCDF should be activated by dialling '995'.

18. **Patient Information Sheet**. Doctors-in-charge can refer patients to the "*Patient Information Sheet*" in **Annex E** for details regarding COVID-19 diagnosis, testing, self-isolation and the recovery process.

Healthcare Subsidies For COVID-19 Treatment

19. **Subsidies Applicable for COVID-19 Treatment**. With effect from **1 Apr 2023,** additional subsidies that were provided for COVID-19 treatment since the start of the pandemic will revert to pre-COVID-19 funding. Where applicable, financial support will revert to the S+3Ms (Subsidies, Medisave, Medishield and Medifund) healthcare financing frameworks. Specifically:

a. **Accident and Emergency department (A&E) – Screening and Treatment**. Regular A&E charges will apply for all patients seeking COVID-19 treatment at any A&E. COVID-19 oral antivirals that are administered at the A&E will remain fully subsidised for all Singaporean Citizens, Permanent Residents and Long-Term Pass Holders (SC/PR/LTPH) who are clinically eligible for the drug until further notice.

[8] For patients who express a requirement to be isolated at a MOH facility due to social reasons, a healthcare provider administered test should be given to verify the patient's COVID-19 positive status, and the results should continue to be submitted.
[9] CMTG will continue conveyancing support between PHIs and CTFs.

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b. **Admissions to CIFs**. The use of CIFs will be chargeable for all patients, regardless of vaccination status. **As CIFs are <u>not</u> medical facilities, patients cannot access the regular financing framework (Subsidies, Medisave and Medishield Life) to pay for these bills**. SCs and PRs who are existing beneficiaries of government financial assistance schemes may receive financial assistance to help defray any out-of-pocket payment.

c. **Admissions to Hospitals and COVID-19 Treatment Facilities (CTFs)**. All patients, regardless of their age or vaccination status, will be required to pay for their inpatient and/or CTF bills, but may access S+2Ms for the payments where eligible. SCs and PRs who face difficulties in paying for their bills may tap on financial assistance to help defray any out-of-pocket payment, if eligible.

d. **Polyclinics and PHPCs – Screening and Treatment**. All patients will be charged (subject to prevailing subsidies) for the investigations (e.g., ART, PCR) utilised.[10] **Until further notice, COVID-19 OAVs will remain fully subsidised**[11] **for clinically eligible patients, regardless of nationality.** Clear documentation of the clinical and eligibility criteria in the relevant reporting systems is essential.

Conclusion

20. This Circular supersedes MOH Circular No. 04/2023 and 04A/2023, and is aligned with the strategy to right-site care and focus resources on managing severe cases and protecting vulnerable patients during endemicity. The strong support from all healthcare providers, healthcare institutions, CTFs, and CIFs is much appreciated. Please email **mopc_operations@moh.gov.sg** for any clarifications.



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[10] The exception would be tests for surveillance (e.g., ARI sentinel surveillance at polyclinics).
[11] Short Term Visitor Pass holder (tourists) can also receive free OAVs at primary care clinics, but not at A&E departments.

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Annexes

A	RISK CRITERIA FOR COVID-19 POSITIVE PATIENTS (ADULTS, PAEDIATRICS, PREGNANT)
B	SIMPLIFIED CHECKLIST FOR PRESCRIBING ORAL ANTIVIRALS (OAV) PAXLOVID & MOLNUPIRAVIR (REVISED)
C	OVERVIEW OF COVID-19 POSITIVE PATIENT TAGGING SCENARIOS
D	MEMO BY MEDICAL PRACTITIONER FOR PERSONNEL MANAGING DECEASED PERSONS WITH SUSPECTED OR CONFIRMED COVID-19
E	PATIENT INFORMATION SHEET

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ANNEX A. RISK CRITERIA FOR COVID-19 POSITIVE PATIENTS (ADULTS, PAEDIATRICS, PREGNANT)

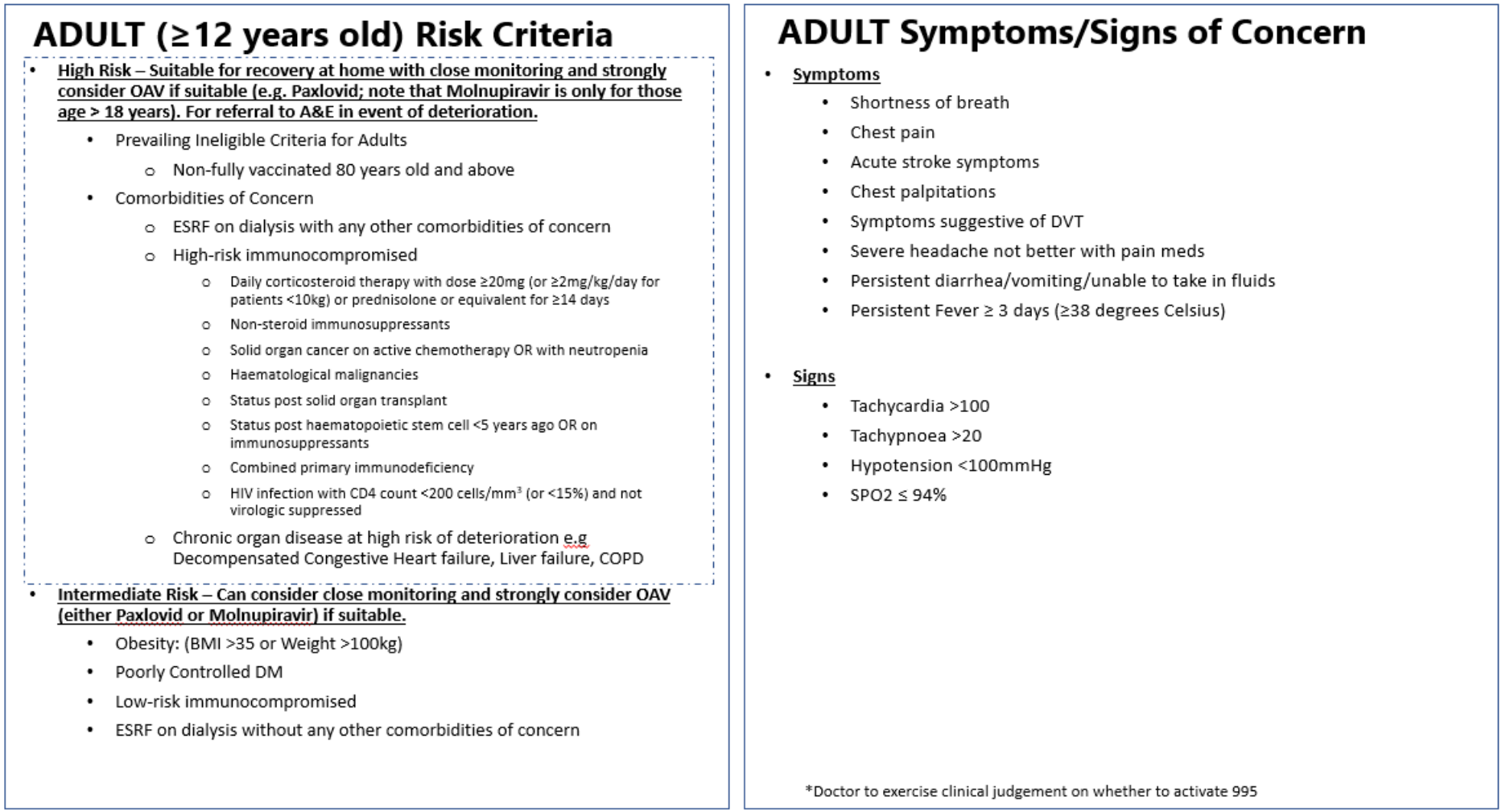


Figure A-1. Adult Risk Criteria and Symptoms/Signs of Concern.

Definition and Care Model for Adult Immunocompromised (High Risk) and Patients with Severe Organ Disease		CAA 9 Feb 2023
Current Definition and Management of Adult (12 years and above) Comorbidities of Concern		
Category	**Definition**	**Case Management**
High risk Immuno-compromised*	Daily corticosteroid therapy with a dose of ≥20 mg (or ≥2 mg/kg/day for patients who weigh <10 kg) of prednisolone or equivalent for ≥14 days	In managing high risk/ severely immunosuppressed patients suspected of having poor vaccine response, doctors should further assess and tailor the management to the individual, including whether the patient should be considered for early therapeutics. Do discuss with the patient's primary physician on further management/disposition, as necessary. <u>Isolation Period</u> • **Recommended** for self-isolation for first 7 days • Can exit self-isolation after 7 days with negative ART or PCR Ct>25 • Maximum isolation period of up to <u>21 days</u>. i.e., Time-based discharge at D21 if persistent ART positive or PCR Ct<25. • Doctors' instructions will take precedence
	On other forms of non-steroid immunosuppressants (non-exhaustive list, examples) • methotrexate >0.4 mg/kg/week • azathioprine >3mg/kg/day • 6-mercaptopurine >1.5 mg/kg/day • Alkylating agents (e.g., cyclophosphamide) • Mycophenolate • Cyclosporine • Tacrolimus • Sirolimus • Biologic immune mediators/therapies (e.g., TNF alpha blockers, rituximab, CAR-T cell therapy, T cell B cell therapy)	
	Solid organ cancer on active chemotherapy OR associated with neutropenia	
	Any history of haematologic malignancies (e.g., leukaemia, lymphoma, myeloma)	
	Status post solid organ transplant	
	Status post haemopoietic stem cell transplant <5 years ago OR currently on immunosuppressants	
	Combined primary immunodeficiency (e.g., Severe combined immunodeficiency)	
	HIV infection with CD4 lymphocyte count <200 cells/mm^3 (or <15%) and not virologic suppressed • In situations of unknown status, HIV patients may be conveyed to CTF on first presentation. Upon confirmation of CD4 count and not virologic suppressed, patient can be deemed low risk immunocompromised and decanted to HRP enhanced, if clinically well.	
Severe Organ Disease	Severe disease affecting heart/lung/liver/brain/nerves, requiring an admission at least once in the past 6 months. (E.g., heart failure, COPD, respiratory failure, liver failure).	All high-risk individuals with severe organ disease should be escalated to the hospital, if acutely unwell <u>Isolation period:</u> • **Recommended** for self-isolation for first 72 hours • Up to 7 days isolation if fully vaccinated • Up to 14 days isolation, if not fully vaccinated • Can exit self-isolation after 72 hours with negative ART

* Please consult the primary physician caring for the patient or relevant specialties if clarifications needed.

Definition and Care Model for Adult Immunocompromised (Low Risk) and Patients with End Stage Renal Failure (ESRF)		CAA 9 Feb 2023
Current Definition and Management of Adult (12 years and above) Comorbidities of Concern		
Category	**Definition**	**Case Management**
End Stage Renal Failure (ESRF)	End Stage Renal Failure on Haemodialysis (HD) or Peritoneal Dialysis (PD)	Isolation period: • **Recommended** for self-isolation for first 72 hours • Up to 7 days isolation if fully vaccinated • Up to 14 days isolation, if not fully vaccinated • Can exit self-isolation after 72 hours with negative ART
Low risk Immunocompromised*	Daily corticosteroid therapy with a dose of<20 mg (or <2 mg/kg/day for patients who weigh <10 kg) of prednisolone or equivalent for ≥14 days	Isolation Period • **Recommended** for self-isolation for first 7 days • Can exit self-isolation after 7 days with negative ART or PCR Ct>25 • Maximum isolation period of up to 14 days. i.e., Time-based discharge at D14 if persistent ART positive or PCR Ct<25.
	On other forms of non-steroid immunosuppressants • methotrexate ≤0.4 mg/kg/week • azathioprine ≤3mg/kg/day • 6-mercaptopurine ≤1.5 mg/kg/day	
	Status post haemopoietic stem cell / bone marrow transplant ≥5years ago AND currently not on immunosuppressants.	
	HIV infection with CD4 lymphocyte count ≥200 cells/mm^3 (or ≥15%) and virologic suppressed	

Category	Definition	Case Management CAA 9 Feb 2023
Not immunocompromised (immunocompetent)	On low dose corticosteroids not amounting to immunocompromised • Not on daily oral/IV corticosteroids • Daily corticosteroid therapy for <14 days continuously • Topical steroids are deemed not to cause immunosuppression • Stopped daily corticosteroids more than 4 weeks ago	You should stay at home until your symptoms resolve. If there is a need to go out while you are symptomatic, or if you are asymptomatic but test positive for COVID-19, please adopt precautions such as: • Wear a mask • Avoid crowded places • Avoid vulnerable settings such as hospitals and nursing homes and contact with vulnerable persons such as the elderly
	Solid organ cancer not on any active chemotherapy and no evidence of neutropenia	
	Hormonal therapy and targeted therapy (including for cancer treatment) that do not result in immunosuppression (e.g., HER2, anti EGFR, anti VEGF)	

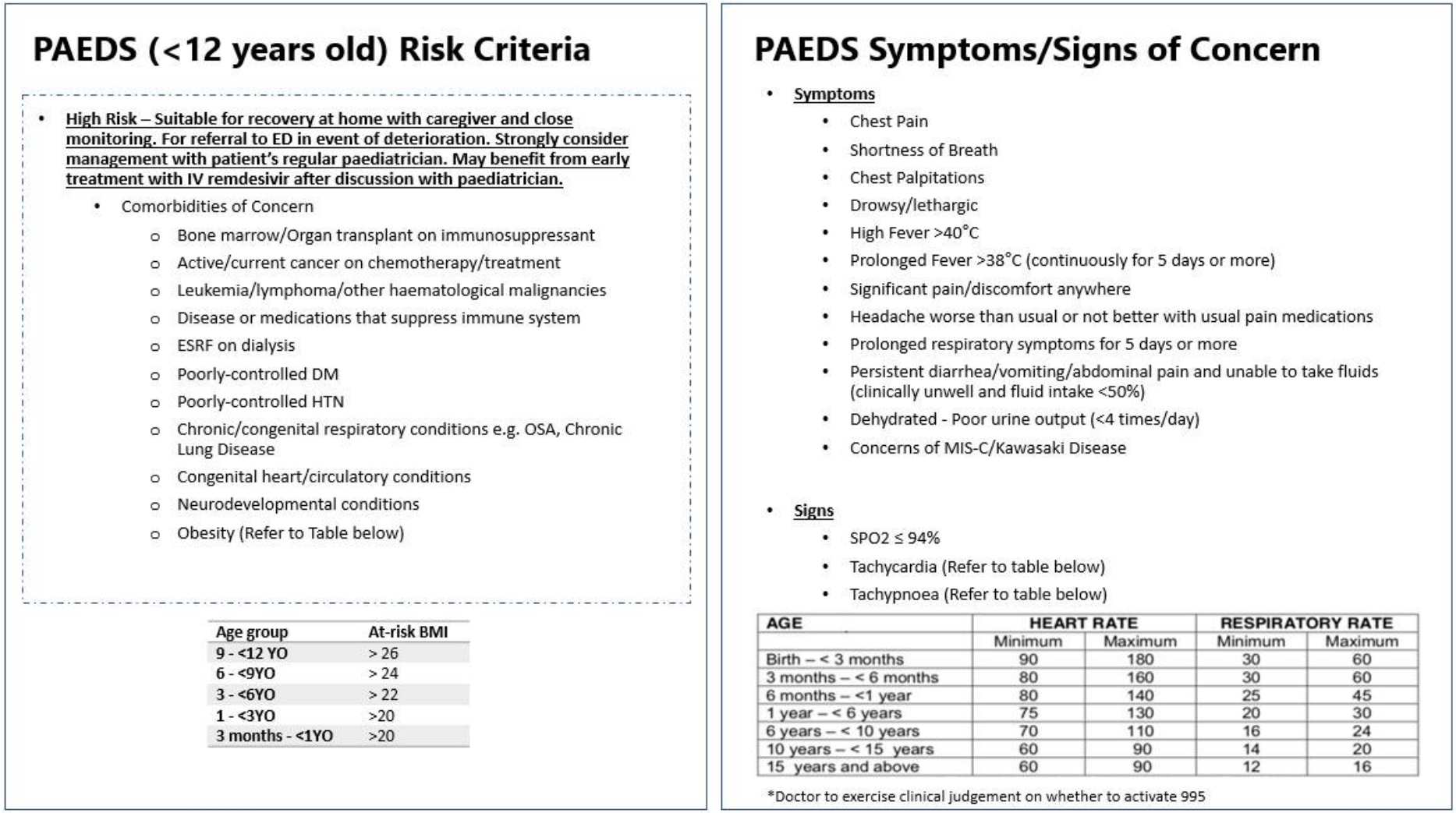


Figure A-2. Paediatrics Risk Criteria and Symptoms/Signs of Concern.

Multi-system Inflammatory Syndrome in Children (MIS-C)

Criteria for case definition of MIS-C

- **All 6 criteria must be fulfilled to meet case definition.**
- However, due to limitations of TM assessment, patients should be conveyed to hospital ED for further evaluation if there is any clinical suspicion of MIS-C.

1) Age 0-19 years old
2) Persistent high fever (>38.5°C) for 3 or more days
3) Signs of multisystem involvement (at least 2 systems below)
    a. Cardiovascular (e.g., raised cardiac biomarkers, pericarditis, coronary abnormalities, ECG abnormalities)
    b. Hypotension or shock (e.g., light-headedness/dizziness)
    c. Gastrointestinal (e.g., diarrhoea, vomiting, abdominal pain)
    d. Mucocutaneous features (e.g., rash, conjunctivitis, mucositis/red, cracked lips and red tongue, swollen hands or feet)
    e. Neurological manifestations (e.g., headache, altered mental state, seizures)
    f. Haematological (e.g., lymphopenia, thrombocytopenia, coagulopathy)
    g. Respiratory (e.g., shortness of breath, tachypnoea)
    h. Renal (e.g., marks of acute renal injury)
4) Elevated markers of inflammation (e.g., CRP, ferritin, Procalcitonin, fibrinogen)
5) Other bacterial/viral causes are excluded AND
6) Evidence of current or recent COVID-19 infection (e.g., PCR-positive, serology positive or antigen positive)

Notes for MIS-C:

- Always have a **high index of suspicion** for children **displaying high fever (>38.5°C) for 3 or more days at presentation and fulfilling 2 or more of the signs of multisystem involvement**, in **confirmed COVID-19 paediatric cases** and **paediatric cases who have recently recovered from COVID-19 infection (within 2 to 8 weeks prior to clinical presentation of MIS-C manifestations)**
- There is significant overlap in the presentations of MIS-C and Kawasaki. Even in the known diagnosis or clinical suspicion of Kawasaki, the recommendation is to still convey these patients to ED for review.

The following two brands of ART kits can be used for children younger than 2 years old. However, they should be administered by healthcare workers.

1. Abbott PanBioTM COVID-19 Antigen Self-Test
2. Acon Biotech Flowflex SARS-CoV-2 Antigen Rapid Test (Self-Testing)
3. SD Biosensor Standard Q

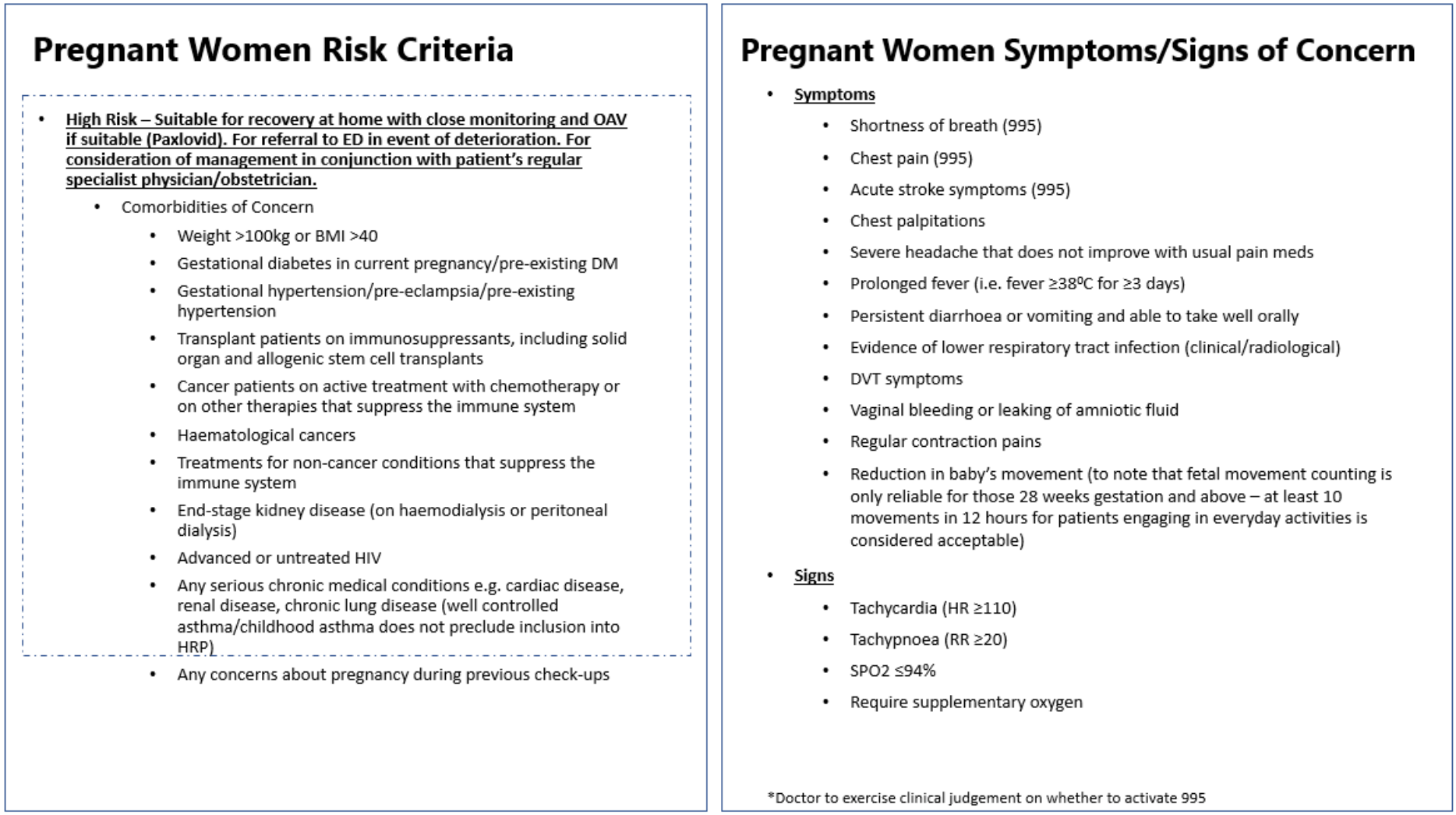


Figure A-3. Pregnant Women Risk Criteria and Symptoms/Signs of Concern.

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ANNEX B. SIMPLIFIED CHECKLIST FOR PRESCRIBING ORAL ANTIVIRALS (OAV) PAXLOVID & MOLNUPIRAVIR: ACUTE & COMM HOSP, ED, PRIMARY CARE, NURSING HOMES, CTF, & HRP

Patient must fulfil ALL the following BASE ELIGIBILITY criteria:

- Within 5 days of onset of symptoms (must be symptomatic)
- Test-confirmed COVID-19 (PCR or Antigen Test Positive)
- ≥18 years old [Adult patient] **OR** ≥12 years old AND weight 40 kg or more [Paediatric patient]
- Does not have severe disease (e.g., hypoxic, SpO2 < 94%)

NB: OAVs should be considered regardless of vaccination status although the option of careful observation/reassessment without OAV therapy may be reasonable if patient is clinically well and with minimum protection[1] for vaccination status, immunocompetent, with no concern for pneumonia and CRP <20 mg/L (if available).

Please note that Paxlovid MAY be crushed for administration if necessary[2], and molnupiravir may be opened for administration through an NG (nasogastric) or OG (orogastric) feeding tube size 12 French or larger[3].

[1] Persons who have completed a primary series and at least one booster dose, such as having received at least three doses of mRNA or Novavax/Nuvaxovid vaccines, or four doses of Sinovac-CoronaVac.
[2] Nirmatrelvir and ritonavir tablets may be split or crushed for administration via a feeding tube or mixed with food or liquid, based on available data that suggests that crushing Paxlovid (nirmatrelvir/ritonavir) does not alter the ritonavir boosting effect and results in comparable nirmatrelvir exposure. Due to lack of information on stability after crushing, it is recommended that any suspension or preparation made with crushed Paxlovid (nirmatrelvir/ritonavir) be consumed/administered immediately. Please see: www.covid19-druginteractions.org/prescribing_resources/paxlovid-crushing-tablets for further details
[3]Please refer to "Fact Sheet for Patients And Caregivers Emergency Use Authorization (EUA) Of LAGEVRIO™ (molnupiravir) capsules For Coronavirus Disease 2019 (COVID-19)" at https://www.fda.gov/media/155055/download and FACT SHEET FOR HEALTHCARE PROVIDERS: EMERGENCY USE AUTHORIZATION FOR LAGEVRIO™ (molnupiravir) CAPSULES at https://www.fda.gov/media/155054/download for details and instructions.

YES & **treatment being considered**

Patient must have 1 or more of the following RISK FACTORS for severe COVID*:

- Age (≥60 regardless of vaccine status)
- Age (≥ 50-59 regardless of vaccine status, Paxlovid may be considered)**
- Active cancer
- BMI ≥25 kg/m² (no minimum protection)
- BMI ≥30 kg/m² (minimum protection)
- Chronic Kidney Disease (CKD)
- Chronic obstructive lung disease (including asthma)
- Serious heart conditions (e.g., heart failure, coronary artery disease, cardiomyopathies)
- Diabetes mellitus
- Ongoing immunosuppressive condition/ treatment

* Patients with 1 or more of the above risk factors and who have clinical or radiographic evidence of pneumonia (if available) or a CRP ≥ 50 mg/L (if available) should be prioritised for treatment.

** Paxlovid initiation can be considered, based on patient-doctor discussion

YES

Does the patient have any of the following CONTRAINDICATIONS to Paxlovid?

- Significant drug-drug interactions that cannot be adjusted for
- GFR < 30mL/ min (no need Renal Function Test if patient has no known renal impairment)
  [Pls refer to next page on drug interactions with Paxlovid/ creatinine clearance]
- Severe hepatic impairment (Child-Pugh Class C) (Not recommended, insufficient data)

NO **contraindications to Paxlovid**

PAXLOVID should be considered as the 1st line (default) OAV treatment

YES **there are contraindications to Paxlovid**

MOLNUPIRAVIR may be considered

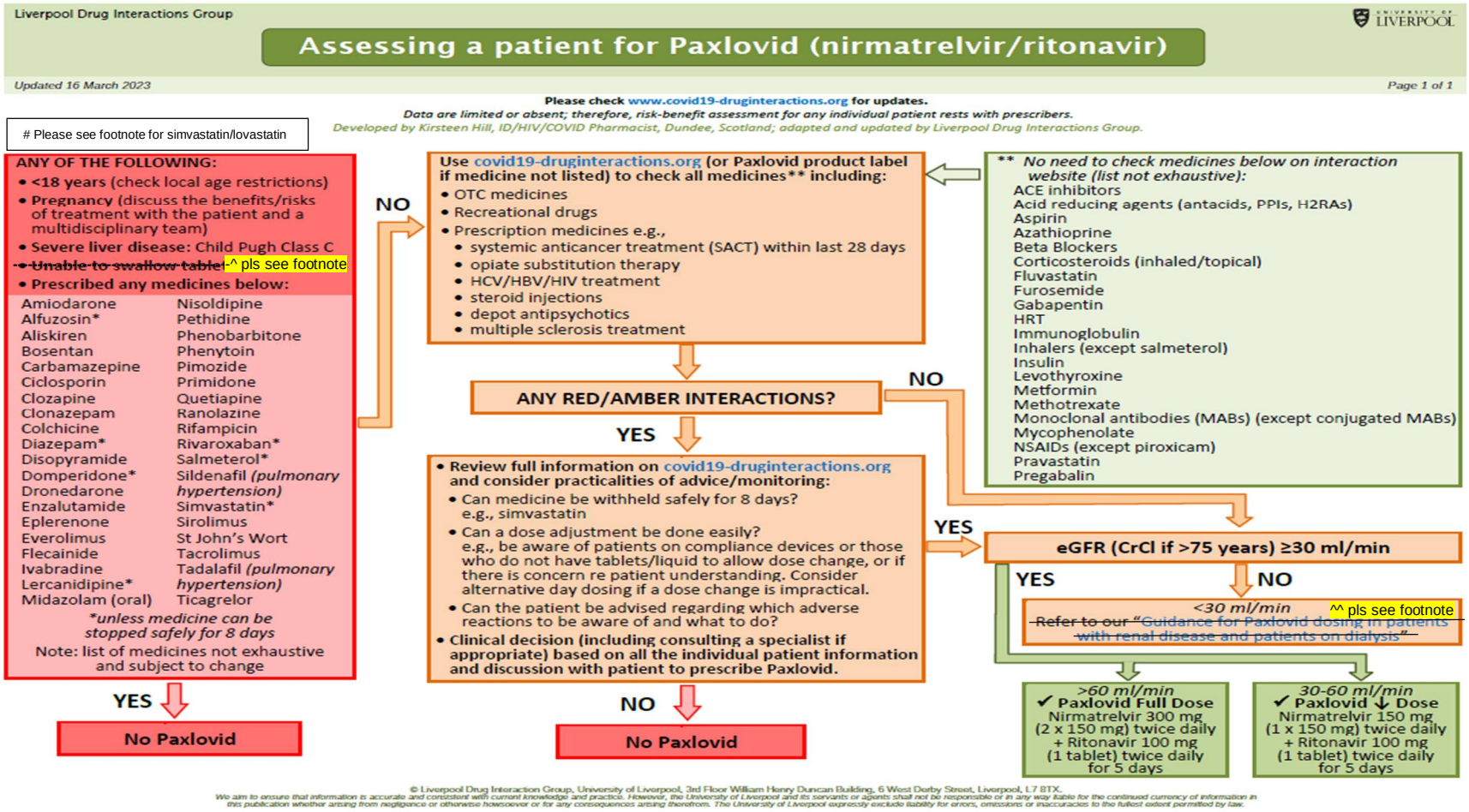
NB: Patient must **not** be pregnant or breastfeeding, and must be ≥ 18 years old. Molnupiravir is not recommended routinely for patients aged between ≥ 50-59 who are without any other risk factors.

Please remember to submit OAV Prescription for each patient prescribed on Patient Risk Profile Portal (PRPP) (applicable for PHPCs only): www.patientprofile.gov.sg

This guidance does not replace sound clinical judgement & professional practice standards. Patient allergy & contraindications must be considered when prescribing these medications. Please refer to drug information sheets, consult patient's primary doctor, pharmacist, or drug interaction database for detailed prescribing guidance

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DRUG INTERACTIONS WITH PAXLOVID (from Liverpool Drug Interactions Group, with addendums^)



eGFR calculator: https://www.kidney.org/professionals/kdoqi/gfr_calculator

 # Note: simvastatin and lovastatin should be discontinued to at least 12 hours prior to starting Paxlovid, and do not restart simvastatin / lovastatin until after 5 days after completing Paxlovid (i.e. stop for a total of 10 days)

^ Note: Paxlovid may be split or crushed for administration via a feeding tube or mixed with food or liquid, based on available data that suggests that crushing Paxlovid (nirmatrelvir/ritonavir) does not alter the ritonavir boosting effect and results in comparable nirmatrelvir exposure. Due to lack of information on stability after crushing, it is recommended that any suspension or preparation made with crushed Paxlovid (nirmatrelvir/ritonavir) be consumed/administered immediately.

^^ Use of Paxlovid when eGFR <30 ml/min is not currently recommended

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ANNEX C. OVERVIEW OF COVID-19 POSITIVE PATIENT TAGGING SCENARIOS

Healthcare Facility	Disposition	Tagging for COVID-19 positive patients
Hospital	Accident and Emergency Department (A&E)	Both FormSG (individual or bulk uploader) can be used depending on the operations workflow of the institutions and the number of expected COVID-positive patients.
	Inpatient (Warded in hospitals)	If result is already submitted by ED, then no need to re-submit. However, if an in-patient gets infected while in the ward, then ward will need to submit result and tagging.
Specialist Outpatient Clinic or Staff Clinic	Patient sent home	Both FormSG (individual or bulk uploader) can be used depending on the operations workflow of the institutions and the number of expected COVID-positive patients.
	Patient referred to ED	Submit result and tagging at the point of testing. • If patient is tested at the SOC, SOC should submit result and tagging. • If patient is referred to ED and tested at the ED, ED should submit result and tagging via FormSG.
Polyclinic	Patient sent home	Submit result and tagging via iConnect.COVID if patients are swabbed at the clinic.
	Patient referred to ED	Submit tagging at the point of testing. • If patient is tested at the Polyclinic, Polyclinic should submit result and tagging. • If patient is referred to ED before being tested, and is subsequently tested at the ED, ED should submit tagging.
GP Clinic	Patient sent home	Submit via PRPP if patients are swabbed at the clinic.
	Patient referred to ED	Submit result and tagging at the point of testing. • If patient is tested at the GP Clinic, clinic should submit tagging. • If patient is referred to ED before being tested, and is subsequently tested at the ED, ED should submit tagging.

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ANNEX D. MEMO BY MEDICAL PRACTITIONER FOR PERSONNEL MANAGING DECEASED PERSONS WITH SUSPECTED OR CONFIRMED COVID-19

Attention: Certifying Medical Practitioner
This memo must be provided to the family of the deceased if one or more of the Table 1 criteria (below) are selected "Yes".

To whom it may concern

Re:

Name of deceased _____

UIN _____

Date & Time of Death _____

Table 1.

Q1. Does the deceased have COVID-19 stated as a cause of death on the certificate of cause of death? This includes causes of death under "Antecedent Causes" and "Other Significant Conditions". This also includes ICD codes containing "coronavirus".	☐ **Yes** ☐ **No**
Q2. Should the deceased be managed as COVID-19 deceased? Select "Yes" if the deceased passed away: i. **in an institutional setting** and was / should have been isolated for suspected or confirmed COVID-19 at the time of demise; or ii. **at home / in the community** and met the prevailing COVID-19 criteria to be advised to isolate at home.	☐ **Yes** ☐ **No**

Note: If the next-of-kin would like the deceased to be embalmed, a list of licensed funeral parlours with embalming facilities is available at https://www.nea.gov.sg/our-services/after-death/post-death-matters/arranging-a-funeral.

Other remarks (optional): _____

_____

Thank you.

Name & MCR: _____ Signature: _____

Date: _____

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ANNEX E. PATIENT INFORMATION SHEET

For patients with mild symptoms, what happens when you test positive for COVID-19?

1. If you have visited a Polyclinic or GP clinic, you will receive an SMS informing you of your Antigen Rapid Test (ART) COVID-19 test results. For other healthcare providers and for Polymerase Chain Reaction (PCR) test done at the polyclinic or GP clinic, you may check HealthHub or with the provider for your test results.

2. You have been issued a Medical Certificate to provide adequate time for you to rest, please take your prescribed medications and recover.

3. Please head home immediately and stay at home until symptoms resolve. While you recover, you are advised to only leave home when necessary (e.g., to seek further medical attention). If there is a need to go out while you are symptomatic, please:

a. Wear a mask
b. Avoid crowded places
c. Avoid vulnerable settings such as hospitals and nursing homes and contact with vulnerable persons such as the elderly

Travelling Between Place of Residence and Healthcare Facilities

4. Commuting on public transport services, such as bus and MRT, is permitted. Patients are to make their own transport arrangements between their place of residence (including nursing/ welfare homes) and healthcare facilities (e.g., PHIs, clinics), and eventually upon discharge. All COVID-19 positive patients and/or patients with ARI symptoms must remain masked regardless of transportation modality**.** In the event of medical emergency, patients should contact SCDF for conveyance via “995”.

Care During Your Recovery at Home

5. You should take appropriate infection prevention control measures during your recovery at home. Should you reside with a vulnerable household member (i.e., non-fully vaccinated elderly 80 years of age and above), preventive measures such as wearing a mask, cleaning the toilet after every use and not sharing a room with other household members should be taken to mitigate infection spread. Alternatively, kindly consider other accommodation arrangements, if possible.

6. Practise good personal hygiene by washing your hands regularly with soap and water.

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7. Please ensure that your family members handle your laundry and trash carefully while wearing gloves, if possible. They should wash their hands with soap after doing so and avoid touching their faces before washing their hands.

8. You may wish to monitor your oxygen saturation using an oximeter and temperature if unwell. No reporting of your readings is required.

9. If you experience worsening symptoms or your symptoms are not improving (e.g., if you are 12 years old and above and experience persistent temperature above 38^{o}C for ≥3days or oxygen saturation below 95%; **OR** if you are below 12 years old and experience prolonged fever above 38^{o}C continuously for ≥5days), please return to your GP/polyclinic for further medical consult. In the event you are unable to access your GP/polyclinic (e.g., after-office hours) and need telemedicine service, please visit "*FluGoWhere"* (https://flu.gowhere.gov.sg/).

10. If you do not have any emergency conditions, please avoid seeking treatment at the A&Es of hospitals and consult your GP/polyclinic or telemedicine providers as above. Individuals with non-emergency conditions turning up at A&Es may be diverted to other clinics for further assessment to prioritise A&E resources for the management of patients requiring acute care. If hospitalisation is not required, clinically stable individuals may also be diverted for admission to COVID-19 Treatment Facilities for further monitoring of their medical conditions.

11. If you experience an emergency (e.g., chest pain, shortness of breath or sudden weakness on one side), call 995 immediately, and inform the ambulance operator that you were diagnosed with COVID-19.

Questions? Go to https://www.moh.gov.sg/covid-19 or contact MOH COVID-19 General Enquiries Hotline at 1800 333 9999

MINISTRY OF HEALTH 13 Aug 2023

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