Symptomatic COVID-19 Patients
Adult (≥ 18 yrs of age)

1. Requiring low-flow O2 supplementation
   Defined as: conventional or reservoir nasal cannula
   flows of < 15 L/min
2. Not requiring ICU level of care for COVID infection

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**Notes**
- Evidence for treatment of COVID-19 and complications from COVID-19 is rapidly evolving
- Safety and efficacy is uncertain in populations excluded from trials, including but not limited to:
  - Concurrent dual antiplatelet therapy
  - Platelets < 50k, Hemoglobin < 8 g/dL
  - Major bleed within past 3 months
  - Intracranial surgery, bleed, or stroke in past 3 months
- In patients with D-Dimer levels rapidly rising but < 1000, consider repeat evaluation for thrombosis with appropriate imaging
- Consider definitive imaging to determine most appropriate duration of anticoagulation

**Renal Failure**
- 30% of COVID-19 patients may develop renal failure
- Heparin should be utilized for those in renal failure or with declining renal function
- Heparin duration of action is shorter and is more easily reversed

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**Start DVT Prophylaxis**
Enoxaparin* 40 mg SubQ daily
Heparin 5,000 units SubQ three times daily
+: Preferred due to reduced patient contact
Consult Pharmacist for bariatric and renal dosing

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**Start Therapeutic Anticoagulation**
Enoxaparin* 1 mg/kg SubQ twice daily
IV Heparin (Low intensity with initial bolus; increase to high intensity if thrombosis present)
+: Preferred due to reduced patient contact
Consult Pharmacist for bariatric and renal dosing

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**Treat for Disseminated Intravascular Coagulation**
Monitor Hemoglobin, platelet count, INR and fibrinogen level Q 4-6 H
- Transfuse one adult dose platelets if platelet count < 50 x 10^9/L
- Administer cryoprecipitate one pool ( = 5 units, volume 110mls) if fibrinogen < 100 mg/dL and 2 pools (220mls) if fibrinogen < 70 mg/dL
- Transfuse FFP 10-15ml/kg if PT/INR remains > 2 and clinically relevant bleeding continues
- Consider tranexamic acid for severe bleeding: 1 gram IV bolus followed by TXA 1 gram in 250 mls NS over 8 hours if the bleeding is gastrointestinal, upper respiratory or genito-urinary. Modify TXA infusion for renal impairment

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**Duration 14 days or until recovery**
*Hospital discharge or liberation from supplemental oxygen for > 24 hrs, whichever comes first

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**Evidence for treatment of COVID-19 and complications from COVID-19 is rapidly evolving**

Lancet. 2022 Dec 15;399:50-59
VTE Prophylaxis after hospital discharge

- Use the **IMPROVE Risk Score** to determine if appropriate to continue VTE prophylaxis after discharge:

<table>
<thead>
<tr>
<th>VTE risk factor</th>
<th>VTE risk score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous VTE</td>
<td>3</td>
</tr>
<tr>
<td>Known thrombophilia</td>
<td>2</td>
</tr>
<tr>
<td>Current lower limb paralysis or paresis</td>
<td>2</td>
</tr>
<tr>
<td>History of cancer</td>
<td>2</td>
</tr>
<tr>
<td>ICU/CCU stay</td>
<td>1</td>
</tr>
<tr>
<td>Complete immobilization ≥ 1 d</td>
<td>1</td>
</tr>
<tr>
<td>Age ≥60 y</td>
<td>1</td>
</tr>
</tbody>
</table>

**Abbreviations:** CCU, cardiac care unit; ICU, intensive care unit; IMPROVE, International Medical Prevention Registry on Venous Thromboembolism; NIH, National Institutes of Health; VTE, venous thromboembolism.

- COVID-19 Patient on Medical Floor Discharge
- No Thrombosis During Hospitalization
- High VTE Risk
  - IMPROVE VTE risk score ≥ 4
  - IMPROVE VTE score of 2-3 with D-Dimer > 500
- Consider discharging with prophylactic anticoagulation x 35 days
  - Enoxaparin 40 mg SubQ daily
  - Apixaban 2.5 mg PO twice daily
  - Rivaroxaban 10 mg PO daily