All COVID LHD Call

May 10, 2022
# Opening Remarks & Leadership Update

| Opening Remarks & Leadership Update | Beth Lovette, RN, BSN, MPH  
Deputy Director/Section Chief  
Local and Community Support |
|-----------------------------------|-------------------------------------------------|
| Epi Picture                        | Zack Moore, MD, MPH  
State Epidemiologist and Epidemiology Section Chief |
| Policy                             | Elizabeth Cuervo Tilson, MD, MPH  
State Health Director and Chief Medical Officer |
| Vaccine Update                     | Carrie Blanchard, PharmD, MPH  
COVID-19 Vaccine Program Manager |
| CI/CT                              | Laura Farrell  
North Carolina Contact Tracing Manager |
| Treatment                          | Tim Davis, PharmD, BCNP, PMP  
Medical Countermeasures Coordinator |

QUESTIONS?
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## Vaccine Update

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NCDHHS COVID-19 Vaccine LHD Update

May 10, 2022

Carrie Blanchard, PharmD, MPH
## AGENDA

<table>
<thead>
<tr>
<th>Slide #</th>
<th>Topic</th>
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<tbody>
<tr>
<td>3</td>
<td>Vaccine Authorization Timeline</td>
</tr>
<tr>
<td>4</td>
<td>5-11 Booster Preparedness</td>
</tr>
<tr>
<td>5</td>
<td>Intend to vaccinate 0-4 within 1st month</td>
</tr>
<tr>
<td>6</td>
<td>COVID-19 Vaccination in Prenatal Populations</td>
</tr>
<tr>
<td>7</td>
<td>Maternal Health Coverage</td>
</tr>
<tr>
<td>8</td>
<td>Pre-perinatal resources</td>
</tr>
<tr>
<td>9-15</td>
<td>Resources</td>
</tr>
</tbody>
</table>
Planning is underway for a June ‘22 launch.

- 609k individuals ages 6 months – 4 years would be eligible for vaccination statewide.
- It is projected that 16% of this population (~90K) will seek vaccination within the first 3 months.
- LHDs and PCPs/Peds will be key in ensuring access across the state
Primary Series Administration by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>1st Dose Admins</th>
<th>% of 1st Doses</th>
<th>2nd Dose Admins</th>
<th>% of 2nd Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fed Pharmacy</td>
<td>80,748</td>
<td>32%</td>
<td>78,104</td>
<td>34%</td>
</tr>
<tr>
<td>Peds</td>
<td>62,609</td>
<td>25%</td>
<td>56,410</td>
<td>24%</td>
</tr>
<tr>
<td>LHDs</td>
<td>27,937</td>
<td>11%</td>
<td>23,516</td>
<td>10%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>16,523</td>
<td>7%</td>
<td>13,640</td>
<td>6%</td>
</tr>
<tr>
<td>Ind. Pharmacy</td>
<td>14,742</td>
<td>6%</td>
<td>12,634</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>50,672</td>
<td>20%</td>
<td>45,986</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>253,231</td>
<td>100%</td>
<td>230,290</td>
<td>100%</td>
</tr>
</tbody>
</table>

5-11 State Inventory by County

Key Takeaways

- More recipients received their primary series from state providers (62%)
- Recipients' behavior for admin location doesn’t appear to vary between 1st and 2nd dose
- There are 182,986 5-11 available doses across state. All northeast counties are low on inventory but have at least one highly dense neighbor except for Currituck and Hertford

- The Pfizer submission was based on clinical trials of administering the booster 6 months after primary series completion. Using this logic, no child in NC is yet eligible.
Lightest blue spaces on the map indicate counties where only the LHDs have the capacity to vaccinate 0-4 populations. Please be prepared to vaccinate groups of **ALL** ages.

- LHDs are in all 100 counties
- LHD prenatal, immunization and pediatric services undergird all vaccination efforts
- CCHC + nurse home visiting programs (CMARC, NFP, CHRMP) support access/confidence for higher risk populations
Emerging research emphasizes the importance of COVID-19 vaccination for both patient and baby. North Carolina prenatal providers and their staff are crucial to combating misinformation and ensuring pregnant individuals and their families have access to vaccination.
MATERNAL HEALTH COVERAGE

LHD Provides:
- Prenatal
- High Risk Maternity Care
- Both
- None (Assures Prenatal Care)

- Activated CVMS OB/GYN
- Equity Focus County
DHHS is focused on leveraging prenatal clinics and high-risk pregnancy programs for COVID vaccination.
RESOURCES
COVID-19 MORTALITY UPDATE

Highlights:

• For a second year, COVID-19 was the third leading cause of death after heart disease and cancer.

• Overall age-adjusted COVID-19 death rate increased from 2020-2021.

• Death rates were highest among American Indian, Alaskan Native, and African American populations.

Read more [here](#).

Make sure we don’t miss an opportunity to save lives through vaccination by having a "Vial in Every Fridge"
NEW BOOSTER COMMUNICATIONS MATERIAL

Booster Social Media Graphics (available in English and Spanish!)

• Facebook
• Instagram
• Twitter
• Whatsapp
NEW SECTIONS
Addressing racism, motivational interviewing, and social stigma

Social Stigma Associated with COVID-19

When talking about coronavirus disease, certain words (e.g., suspect case, isolation) or phrases might have negative connotations for patients, or fuel stigmatizing attitudes. By using intentionally language, we can avoid perpetuating negative stereotypes and the dehumanization of those who have the disease. Here are some examples of how to use inclusive, less-stigmatizing language in vaccine conversations:

DO: Talk about the new coronavirus disease (COVID-19)

Don’t attack locations or ethnicities to the disease, this is not a “Wuhan Virus,” “Chinese Virus” or “African Virus,” even if the patient refers to it as such.

DO: Talk about “people who have COVID-19,” “people who are being treated for COVID-19,” “people who are recovering from COVID-19” or “people who died after contracting COVID-19.”

Don’t refer to people with the disease as “COVID-19 cases” or “victims.”

UPDATED VACCINE CONVERSATION GUIDE

REFORMATTED!
Structured stock response answers to top questions

Suggested answers for questions about vaccine safety and development:

Identify

Are there specific concerns? What have they heard? Are they afraid of the vaccines?

You might say

If they say

Are the vaccines safe?

All of the vaccines (Pfizer, Moderna, and J&J) provide significant protection against COVID-19. They all protect against virus-related hospitalization and death. There were no serious safety concerns in any of the clinical trials.

Who makes sure the vaccines are safe and can prevent COVID-19?

The U.S. Food and Drug Administration (FDA) makes sure all food and drugs are safe. The COVID-19 vaccines must pass clinical trials like other drugs and vaccines. The FDA checks the work and authorizes vaccines only if they are safe and effective. Because vaccines are given to millions of healthy people to prevent serious disease, they’re held to very high safety standards.
NEW VACCINE STORAGE ONE PAGER

Click here to view the new Storage and Handling One-Pager!
The COVID-19 Provider Guidance document has been updated! Access it here.
RECORDING AVAILABLE: COMMUNITY COLLABORATION AND COVID-19

Topic

Be a Superhero: How to Increase COVID-19 Vaccine Uptake in Schools through Community Collaboration

Description

Learn to develop partnerships between local school districts, CBOs, and LHDs to reduce COVID-19 and increase equitable access to vaccines for school-aged children and their families.

Recording

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• During 2022, NC DPH plans to support staffing based on prioritized outreach; LHDs should assess their local contact tracing needs and plan to staff appropriately with LHD hired staff
• After 2022, NC DPH plans to retain a CI/CT central support team that can support LHDs
• As always, the future is unpredictable
**ESTIMATED APRIL 2022 – APRIL 2023 CONTACT TRACING STRATEGY**

### REDUCE

- Reduce CCTC staffing to levels appropriate for prioritized outreach; most phone calls replaced with digital outreach (Now)
- Lighter touch digital notification; shift from unique case portal to one static landing page (Spring 2023)

### REFOCUSE/RETAIIN

- CCTC staff direction shifts from LHDs to DPH (Winter 2022)
- Maintain a core of CCTC staff for outbreak deployment, call center and data entry (through at least Spring 2023)

### EXPAND

- Use the learning opportunity: Pilot notification for another communicable disease in CCTO (Now with Guilford County)
- Develop CI/CT functionality from in NC COVID
  - Texting
  - Referrals (Now-Spring 2023)
<table>
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<th>Potential Shifts in Pandemic Epidemiology</th>
<th>Contact Tracing Response</th>
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<td>Morbidity reduced by vaccine/immunity (regardless of length of incubation period)- Current State</td>
<td>Do not staff up; LHD-based CI/CT for congregate living setting outbreaks</td>
</tr>
<tr>
<td>Worse morbidity or morbidity shifts to include younger people with shorter or similar incubation period</td>
<td>Disease can’t be controlled by contact tracing; staff up to support outreach to essential workers</td>
</tr>
<tr>
<td>Worse morbidity or morbidity shifts to include younger people with longer incubation period</td>
<td>Consider state-wide staff up; would require rapid implementation.</td>
</tr>
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LHD FUTURE STAFFING SURVEY RESULTS

- 65 LHDs responded

- Full survey results distributed last week to all LHD Directors by Beth Lovette

- If you did not receive the results and would like a copy, please email me at Laura.Farrell@dhhs.nc.gov.

- Next step: Outreach to LHDs who noted they are not following case investigation guidance or have other potential staffing concerns to learn and discuss

**Percentage of Health Departments Following State Prioritization Guidance for Cases**

- 11, 17%
- 28, 43%
- 20, 31%
- 6, 9%

- Fully following (Calling priority groups 1-4)
- Partially following (Calling priority groups 1-2 only)
- Not following (Calling all cases**)
- Unable to determine (Incomplete Answer)
NEST STEPS FOR REFERRALS IN CONTACT TRACING

Learning from our experience
Review referral outcomes from COVID-19 contact tracing and HIV contact tracing

Adapting our tools
- Use learning from CCTO referral package to create NC COVID referral package
- Based on comparison of resource referrals, expand referral options for communicable disease to support additional resource referrals for any disease for which contact tracing is performed
- Create pathway for NC CARE 360 referrals for all contact tracers
- Work with other DPH/DHHS programs for streamlined NC CARE 360 engagement

WHAT THIS MEANS:
- Continues to focus on importance of connections
- Continues to work toward MOST EFFICIENT use of disease outreach to benefit our community
- Strengthens “no wrong door” access at NC DHHS


Contact Tracing data from CCTO
HIV data from Medical Monitoring Project
Most frequently reported needs are shown

Proportion of those expressing resource need

- People living with HIV
- People with COVID-19
# Treatment

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COVID-19 Therapeutics Update
**Legacy Monoclonal Antibodies – No Longer Authorized for Use**

Please note: REGEN-COV and Bam/Ete are not authorized for use at this time due to their markedly reduced activity against the Omicron variant, Sotrovimab is not authorized for use at this time due to its markedly reduced activity against the BA.2 Omicron sub-variant.

Monoclonal antibodies, or mAbs, are antibodies made in a laboratory to fight a particular infection. The Food and Drug Administration (FDA) has issued Emergency Use Authorization (EUA) for the use of monoclonal antibody therapies for adult and pediatric patients aged 12 and older (Bam/Ete authorized for all ages). mAbs are given to patients with an infusion, subcutaneous injection, or intramuscular injection. They are used for treatment or prevention. As previously mentioned, the following are not authorized for use for COVID-19 at this time:

<table>
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<th>Dosing Regimen</th>
<th>Authorized Patient Population</th>
<th>Standing Order?*</th>
<th>Efficacy</th>
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</table>
| Casirivimab / imdevimab | Casirivimab   | REGEN-COV  
Post-exposure Prophylaxis, Treatment within 10 days of symptoms | Subcutaneous Injection; Intravenous Infusion | 600 mg of both | Patients aged 12 years and older              | No, rescinded January 24th | 70% effective in preventing hospitalizations or deaths within five (5) days of symptom onset  
Reduced efficacy against Omicron |
| Bamalanvimb / etesevimab | Bam/Ete      | Bam/Ete  
Post-exposure Prophylaxis, Treatment within 10 days of symptoms | Intravenous Infusion | Dosage varies with weight | Patients of all ages, including neonates | No, rescinded January 24th | 87% effective in preventing hospitalizations or deaths within five (5) days of symptom onset  
Reduced efficacy against Omicron |
| Sotrovimab           | Sotrovimab    | Sotrovimab  
COVID-19 Treatment within seven (7) days of symptoms | Intravenous Infusion | 500 mg of sotrovimab | Patients aged 12 years and older and weighing at least 40 kg | No, rescinded April 6th | 79% effective in preventing hospitalizations or death.  
Limited effectiveness against the BA.2 Omicron sub-variant |

*Per the Public Readiness and Emergency Preparedness Act, pharmacies were added to the eligible providers and can now administer monoclonal antibody treatment*
**MONOCLONAL ANTIBODIES – CURRENTLY AUTHORIZED**

Monoclonal antibodies, or mAbs, are antibodies made in a laboratory to fight a particular infection. The Food and Drug Administration (FDA) has issued Emergency Use Authorization (EUA) for the use of monoclonal antibody therapies for adult and pediatric patients aged 12 and older. mAbs are given to patients with an infusion, subcutaneous injection, or intramuscular injection. They are used for treatment or prevention. The following mAb products are currently authorized that are effective against currently circulating SARS-CoV-2 variants:

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| Bebtelovimab       | Bebtelovimab  | COVID-19 Treatment within seven (7) days of symptoms   | Intravenous Infusion    | 175 mg of bebtelovimab             | Patients aged **12 years and older** and weighing at least 40 kg | Yes, as of February 15th                                                              | Placebo controlled trial data not available to determine % effectiveness at reducing hospitalization  
Retains efficacy against Omicron and the BA.2 Omicron subvariant                      |
| Tixagevimab / cilgavimab | EVUSHELD AZD7442 | Pre-exposure prophylaxis (PrEP)                         | Intramuscular Injection | 300 mg of tixagevimab and 300 mg of cilgavimab | Patients aged **12 years and older** who are immunocompromised or have a contraindication for COVID-19 vaccines | No – per FDA/HHS                                                                      | 77% effective in preventing SARS-CoV-2 RT-PCR symptomatic illness  
Higher dose may be more likely to prevent infection by the COVID-19 Omicron subvariants BA.1 and BA.1.1 |

*Per the Public Readiness and Emergency Preparedness Act, pharmacies were added to the eligible providers and can now administer monoclonal antibody treatment*
Antiviral Treatments
The FDA has issued **EUAs** for the use of oral antiviral therapies for adult and pediatric patients aged 12 and older (molnupiravir authorized for 18+ only). Oral antivirals are administered orally and only used for treatment. The following oral antivirals products are currently authorized that are effective against currently circulating SARS-CoV-2 variants. Both therapeutics target mild-to-moderate COVID-19 for adults who are at risk of severe illness:

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<th>Dosing Regimen</th>
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<th>Standing Order?</th>
<th>Efficacy</th>
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<td>Molnupiravir</td>
<td>MK-4482, Merck, LAGEVRIO</td>
<td>Treatment of mild-to-moderate COVID-19 in adults who are at risk for progressing to severe COVID-19 and for whom alternate treatment is not accessible or clinically appropriate</td>
<td>Oral</td>
<td>Must start <strong>within five (5) days</strong> of symptom onset</td>
<td>800 mg twice-daily for five (5) days</td>
<td>Adult patients aged 18 years and older</td>
<td>No – per FDA/HHS</td>
<td>30% effective in preventing hospitalizations or deaths within five (5) days of symptom onset Retains efficacy against Omicron</td>
</tr>
<tr>
<td>Nirmatrelvir / Ritonavir</td>
<td>PAXLOVID, Pfizer</td>
<td>Treatment of mild-to-moderate COVID-19 in adult and pediatric patients (12+) who are at risk for progressing to severe COVID-19</td>
<td>Oral</td>
<td>Must start <strong>within five (5) days</strong> of symptom onset</td>
<td>Standard: 300 mg of nirmatrelvir and 100 mg of ritonavir twice-daily for five (5) days Renal impairment: 150 mg of nirmatrelvir and 100 mg of ritonavir twice-daily for five (5) days</td>
<td>Patients aged 12 years and older</td>
<td>No – per FDA/HHS</td>
<td>88% effective in preventing hospitalizations or deaths within five (5) days of symptom onset Expected to maintain effectiveness across all variants</td>
</tr>
</tbody>
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Please Note: VEKLURY (remdesivir) is not allocated by the federal government and only available commercially.

Veklury is an antiviral medication that works by inhibiting an enzyme that is essential for SARS-CoV-2 viral replication. The FDA has granted full approval for treatment in both hospitalized and non-hospitalized patients who are 12 years of age or older. The FDA has also granted full approval for treatment in both hospitalized and non-hospitalized patients at least 28 days of age and older weighing at least 3 kg.

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<tr>
<td>Remdesivir</td>
<td>VEKLURY</td>
<td>Full FDA Approval</td>
<td>Intravenous Infusion</td>
<td>May only be administered in settings in which healthcare providers have immediate access to medications to treat severe infusion or hypersensitivity reactions and the ability to activate EMS. For non-hospitalized patients, treatment must be initiated as soon as possible after diagnosis and within seven (7) days of symptom onset</td>
<td>For patients weighing 40kg or greater: 200mg loading dose on Day 1, followed by a once-daily maintenance dose of 100mg from Day 2. For patients weighing less than 40kg: 5mg/kg loading dose on Day 1, followed by a once-daily maintenance dose of 2.5mg/kg from Day 2</td>
<td>No</td>
<td>87% effective at preventing hospitalization/death compared to placebo in non-hospitalized patients considered at high-risk for progression to severe COVID-19. Retains efficacy against Omicron</td>
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| Remdesivir   | VEKLURY       | Full FDA Approval   | Intravenous Infusion    | May only be administered in settings in which healthcare providers have immediate access to medications to treat severe infusion or hypersensitivity reactions and the ability to activate EMS. For non-hospitalized patients, treatment must be initiated as soon as possible after diagnosis and within seven (7) days of symptom onset | For patients weighing 40kg or greater: 200mg loading dose on Day 1, followed by a once-daily maintenance dose of 100mg from Day 2. For patients weighing less than 40kg: 5mg/kg loading dose on Day 1, followed by a once-daily maintenance dose of 2.5mg/kg from Day 2 | No | 87% effective at preventing hospitalization/death compared to placebo in non-hospitalized patients considered at high-risk for progression to severe COVID-19. Retains efficacy against Omicron |

Patient and Treatment Prioritization
**TREATMENT PRIORITIZATION**

**Preferred Treatments**

For non-hospitalized patients with mild to moderate COVID-19 who are at high risk of disease progression, the NIH Panel recommends using one (1) of the following therapeutics (listed in order of preference):

1. Paxlovid
2. Remdesivir*

*Remdesivir is not allocated by the federal government and is only available for private purchase

Note: At this time, REGEN-COV and bamlanivimab and etesevimab are no longer authorized for use due to available data that shows these products are not effective against the Omicron variant. Sotrovimab is no longer authorized for use due to available data that shows it is not effective against the BA.2 Omicron sub-variant.

**Alternative Treatments**

If none of the preferred therapies for high-risk, non-hospitalized patients are available, feasible to deliver, or clinically appropriate (e.g., due to drug-drug interactions, concerns related to renal or hepatic function), the Panel recommends using 1 of the following therapies (listed in alphabetical order):

1. Bebtelovimab
2. Molnupiravir
COVID-19 therapy is open to all individuals that qualify, per the terms of the EUAs and FDA guidance

A large proportion of the North Carolina population is considered high risk based on age or underlying conditions. Therefore, anyone with a COVID-19 diagnosis should be carefully evaluated for potential treatment options. These therapies have demonstrated effectiveness against currently circulating SARS-CoV-2 variants, and many have been clinically proven to be effective in preventing hospitalization or death.

NC DHHS Provider Guidance Memo
Distributed April 21, 2022

CDC Health Alert Network (HAN) Advisory
Distributed April 25, 2022
Test to Treat Program
Test to Treat (T2T) is a nationwide initiative that provides individuals a more effective way to rapidly access lifesaving treatment for COVID-19.

In this program, people can get tested and – if they are positive and treatments are appropriate for them – receive a prescription from a healthcare provider, and have their prescription filled all in one location.

**T2T Site Requirements**
- Rapid COVID-19 testing on-site (or evaluation of at-home testing)
- Linkage to a clinical evaluation by licensed healthcare provider after positive result to provide prescription when appropriate
- **Co-located pharmacy** able to readily dispense medication to eligible patients
- Provide services to all individuals, regardless of insurance status

**Federal T2T Program**
- Federal Retail Pharmacy Partners
- Supported via direct federal allocations
- In NC – 74 CVS, 3 Walgreens, and 3 FQHCs

**State T2T Sites**
- State identified providers that meet T2T requirements
- Supported via state allocations
- 67 State identified sites (Pharmacies, Hospitals, PCPs, LHDs, FQHCs, and more)

Existing providers interested in becoming a T2T provider, please fill out the Test to Treat Program Eligibility Survey
New providers can identify as T2T locations as part of the Enrollment Process
Click here to view the COVID-19 Test to Treat Fact Sheet
ORAL ANTIVIRAL DISPENSING GUIDANCE

Physicians, advanced practice registered nurses, and physician's assistants with active licensure and in good standing with their respective governing bodies can prescribe and dispense oral antivirals for treatment of COVID-19 in accordance with the PAXLOVID and molnupiravir EUAs, from their offices, if the following conditions are met:

1. There is absolutely no charge to the patient for the drug or act of dispensing, including seeking reimbursement of dispensing fees through third-party payors
2. Products are labeled in accordance with State and Federal dispensing laws. Details from the NC Board of Pharmacy on what information must be included on a prescription label can be found here

Physicians who wish to dispense oral antivirals for the treatment of COVID-19 (or any other medication) for a fee must be registered with the NC Board of Pharmacy as a dispensing physician.

Nurse Practitioners and Physician's Assistants who wish to dispense medications other than COVID-19 therapeutics (whether a fee is charged or not) or who wish to dispense COVID-19 therapeutics for a fee must register with the Board of Pharmacy as a dispensing nurse practitioner or physician's assistant.

For more information on becoming a dispensing physician, nurse practitioner, or physician's assistant please visit the NC Board of Pharmacy Dispensing Physician, Physician Assistant and Nurse Practitioners Registration Requirements.
COVID-19 Treatment Costs
COVID-19 TREATMENT COSTS

- Patient costs for COVID-19 depend on the type of treatment and the patient’s insurance status/type of insurance.
- The drug products themselves are paid for by the federal government, however providers are allowed to charge an administration or dispensing fee. There may also be costs for testing/evaluation services.

Uninsured Individuals
- Federal T2T locations are required to provide COVID-19 oral antivirals at no cost to uninsured patients. However, there may be a charge for the testing or evaluation portions of the T2T process.
- Currently we know CVS is not charging uninsured individuals for T2T services as long as they are tested at CVS. We are working to understand other provider policies around uninsured individuals.

Medicare and Medicaid Recipients
- These programs are currently covering all costs associated with COVID-19 Treatments. No out-of-pocket costs.

Individuals with Private Insurance
- Type of treatment may determine cost. Individuals should check with their insurance provider.
- For oral antivirals there should be no copay at time of dispensing. Providers may bill insurance for testing or evaluation pieces.
- For mAbs provider will likely bill insurance for the administration fee, coverage varies by insurance.
Current Therapeutics Snapshot
THERAPEUTICS: CURRENT STATE SNAPSHOT (DATA AS OF 05/03)

**Average Distance to Provider in miles**
- **4.90 (↓0.24)**

**Total # T2T Providers (# locations with current inventory)**
- **109 (↑4)**

**Total Providers with Inventory**
- **1,221 (↑23)**

**Bebtelovimab**
- **4,411**

**Molnupiravir**
- **40,961**

**Paxlovid**
- **27,692**

**Current on-hand Inventory across NC**
- **Total # T2T Providers (locations with current inventory)**
- **109 (↑4)**

**Utilization Data Caveats:**
- Treatment administrations are still being historically adjusted in HPOP
- Molnupiravir allocation & admins excluded from analysis
- Sotrovimab was deauthorized for use on 4/5
- Weekday timeline from Wed-Tues due to historical sotrovimab reporting

**Legend**
- **Left, Darker Shades:**
  - Purple: Sotrovimab Allocation
  - Teal: Paxlovid Allocation
  - Blue: Bebtelovimab Allocation
  - Pink: Renal Pax Allocation
- **Right, Lighter Shades:**
  - Purple: Sotrovimab Admins
  - Teal: Paxlovid Admins
  - Blue: Bebtelovimab Admins
  - Pink: Renal Pax Admins
- **Red Dot:**
  - Total Utilization Rate: (Total Admins/Total Allocation)*100

*Treatment products include: Bebtelovimab, Paxlovid (including Renal) and Molnupiravir

**(X): +/- change from 04/28/2022
Average distance from a home to a provider with Bebtelovimab and/or Paxlovid by Zip Code

- **National average distance to hospital by county density**

- **Avg. distance (miles) to provider with Bebtelovimab and/or OAV:** 4.90
- **Longest travel distance (miles):** 20.30
- **Avg. distance of top 25%:** 10.27

*National average distance to hospital by county density*
THERAPEUTICS WAYFINDING

1. Public Facing Test to Treat Site Finder

Test to Treat in 4 Easy Steps

1. Search your zip code or city in the map below.
2. Get tested.
3. Get a prescription if you test positive and treatment is right for you.
4. Get your prescription filled, all at one location.

Don’t see a spot near you? There are hundreds more treatment locations across N.C. You’ll need a prescription for sites that are not Test to Treat, so check with your health care provider. Need help? I need a ride?

Find an Evusheld provider near you:

Enter your zip code or city to search the map below for a provider that offers Evusheld near you.

- Appointments and prescription required at all locations.
- To set up an appointment, call the phone number listed for the location you want to visit.

2. Filterable Provider Focused Site Finder (Includes all products in one location)

3. Public Facing Dedicated Evusheld Site Finder
Resources
RESOURCES

NC DHHS Therapeutics Provider Request Form

NC DHHS Find COVID-19 Treatment website

NC DHHS Therapeutics Information for Providers

NC DHHS Provider Playbook: COVID-19 Outpatient Therapeutics

NC DHHS Smartsheet Therapeutics Provider Hub

Join our NC DHHS therapeutics provider listserv

ASPR COVID-19 Therapeutics Allocation/Threshold Dashboard