CDC/IDSA COVID-19 Clinician Call

February 13, 2021

Q&A

This is the Q&A transcript from the Zoom webinar, formatted and edited for spelling and grammar only. There are an additional two questions at the end of this document that were answered via email by the presenters following the call. The views and opinions expressed here are those of the presenters and do not necessarily reflect the official policy or position of the CDC or IDSA. Involvement of CDC and IDSA should not be viewed as endorsement of any entity or individual involved.

1. **Have these recs been sent to prescribing docs yet?**

   CDC is trying to raise awareness of prescribing of unauthorized treatments for COVID-19 with the data presented and encourage clinicians to use NIH COVID-19 Treatment Guidelines. https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html.

2. **Is ivermectin effective in COVID-19?**

   The NIH Treatment Guidelines currently state that insufficient data for the COVID-19 Treatment Guidelines Panel (the Panel) to recommend either for or against the use of ivermectin for the treatment of COVID-19. Well-designed clinical trials are needed. https://www.covid19treatmentguidelines.nih.gov/antiviral-therapy/ivermectin/.

3. **What are adverse effects of Zinc seen?**

   The NIH COVID-19 Treatment Guidelines mention that long-term zinc supplementation can cause copper deficiency with subsequent reversible hematologic defects (i.e., anemia, leukopenia) and potentially irreversible neurologic manifestations (i.e., myelopathy, paresthesia, ataxia, spasticity). In addition, oral zinc can decrease the absorption of medications that bind with polyvalent cations. Because zinc has not been shown to have a clinical benefit and may be harmful, the Panel recommends against using zinc supplementation above the recommended dietary allowance for the prevention of COVID-19, except in a clinical trial (BIII). https://www.covid19treatmentguidelines.nih.gov/supplements/zinc/.

4. **What is CDC doing to prevent quacks from prescribing practices well demonstrated by these data?**

   CDC is trying to raise awareness of prescribing of unauthorized treatments for COVID-19 with the data presented and encourage clinicians to use NIH treatment guidelines. https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html.

5. **Is not giving dexa for patients without need for oxygen a mistake?**

   NIH treatment guidelines recommend dexamethasone for hospitalized patients requiring oxygen but do not recommend dexamethasone for outpatients who do not require oxygen https://www.covid19treatmentguidelines.nih.gov/therapeutic-management/.

6. **Does the increase in dexamethasone refer to critically ill patients in ICU or to the general population of patients?**

   These data represent outpatient retail prescription claims and do not include use in inpatient settings.

7. **Sorry, what I meant is: is giving dexa to patients not in need of oxygen not a mistake?**

   NIH treatment guidelines recommend dexamethasone for hospitalized patients requiring oxygen but do not recommend dexamethasone for outpatients who do not require oxygen. https://www.covid19treatmentguidelines.nih.gov/therapeutic-management/.

8. **We need to do more to increase awareness amongst non-ID clinicians nationwide that steroids should not be given in the early viremic phase and only with evidence of hyperinflammation (desaturation, elevated markers). We are only involved once patients are sick enough to be admitted.**

   We agree. And hope that publication of information that generalist clinicians are prescribing medications that are not authorized will raise attention to this issue.

9. **Will there potentially be an EUA for early treatment for patients who currently are asymptomatic, but have a known recent close contact exposure? the EUA states "within symptom onset" - implying symptoms are required. Acknowledging for incidental positives (no known close contacts), we won't know how long that person has been infected.**

   The data supporting the EUA come from trials where patients needed to have at least one COVID-19 symptom.

10. **Colchicine in COVID-19?**

    NIH Treatment Guidelines do not currently address colchicine that will be reviewed as they are completed.

11. **The monoclonal antibodies must be administered in high-risk patients with high viral loads or its administration is independent of the viral load?**

    Administration is independent of viral load.

12. **Can we give a hospitalized patients monoclonal infusion if the primary reason for hospitalization is for a non-COVID-19 reason (renal stone, acute MI, stroke, trauma) but are not hypoxic or requiring oxygen for hypoxemia, and otherwise qualify?**

    Yes - patients who are hospitalized for a reason other than COVID-19 and are not hypoxic would be eligible for treatment.

13. **Why were patients >65 yo and obese excluded from the trial - these are two major at-risk patient populations?**

    Obese patients and obese patients were included in the phase 3 portion of BLAZE-1; BLAZE-4 was a phase 2 trial that did not enrich for high participants.

14. **Are the new variants identified in participants in the BLAZE-4?**

    This trial is ongoing and viral samples are still being sequenced.

15. **Did BLAZE studies include immunocompromised?**

    Yes, this was considered to be a risk factor for disease progression in BLAZE-1.

16. **Was there standardization of the CT data? I am referencing letter to CID from August 2020, where CT data were very variable, depending on lab, instrument, even within a lab on the same machine.**

    Yes, and these samples were analyzed at a central lab.

17. **Since patients over 65 were excluded in BLAZE-4, how comfortable do you feel with the suggested dosing?**

    We feel comfortable with the dosing based on the totality of available data.

18. **How many children were in these trials? I don't understand the initial use down to 12 years old and the initial inclusion of a number of risk factors in the pediatric age group that did not seem to have any data to support them.**

    A limited number of adolescents were enrolled in BLAZE-1.

19. **Were ER stays > 24 hrs. included in primary endpoint?**

    They were included as part of the primary endpoint for the phase 2 portion of BLAZE-1

20. **The EUA permits symptom onset up to 10 days, but the studies have data for median 4 days. As we are using this as an antiviral, earlier is likely better, -- is there any data to show the effectiveness at 10 days?**

    Yes, the majority of subjects enrolled (>90%) had enrolled prior to day 10 and all subjects were included in the efficacy analyses.

21. **What is the current position on COVID-19 Convalescent Plasma?**

    The NIH Treatment Guidelines currently state that there are insufficient data for the COVID-19 Treatment Guidelines Panel (the Panel) to recommend either for or against the use of COVID-19 convalescent plasma for the treatment of COVID-19.

    https://www.covid19treatmentguidelines.nih.gov/anti-sars-cov-2-antibody-products/convalescent-plasma/.

22. **Is there a possibility of more ADE with monoclonal antibodies? In which patients?**

    There is no evidence ADE at this time.

23. **Why bam is not recommended for hospitalized patient with immunocompromised status, obesity, etc who get COVID-19 in the hospital and are high risk for progression?**

    High risk patients that are hospitalized for non-COVID reasons would be eligible for bam and ete, as long as they do not develop an oxygen requirement due to COVID. See wording in the HCP factsheet:

    Bamlanivimab and etesevimab are not authorized for use in patients:

    - who are hospitalized due to COVID-19, OR
    - who require oxygen therapy due to COVID-19, OR
    - who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity.

24. **So, BAM alone should not be used anymore?**

    No, bam alone is still authorized under EUA and is an option for treatment.

25. **Is the combination of Bam and Ete not indicated for patients older than 65 or with BMI > 35?**

    Bam and ete are indicated for high-risk patients and >65 and BMI >35 are both considered to be risk factors under the EUA.

26. **If the dose is fixed 700:1400, why are the infusion times different. are they? may be i missed something.**

    It may depend on the size of the available infusion bags.

27. **Is there any data supporting use of BAM or ETE for treating kids with COVID-19?**

    A small number of high-risk adolescent patients are included in the phase 3 portion of Blaze-1.

28. **How does this combination compare with the Regeneron MAB combination with regard to efficacy?**

    These antibodies have not been studied within the same clinical trial.

29. **Any thoughts on Fluvoxamine for covid-19?**

    NIH Treatment Guidelines do not directly address fluvoxamine. We did not see large increases in prescribing to date. NIH Treatment panel will be reviewing well designed randomized trial results as they are available.

30. **Should BAM/ETE be indicated only for COVID-19 outpatients whose oxygen sats are above 94% not requiring oxygen supplementation?**

    Yes. Bamlanivimab and etesevimab are not authorized for use in patients:

    - who are hospitalized due to COVID-19, OR
    - who require oxygen therapy due to COVID-19, OR
    - who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity.

31. **Can we combine ETE with the existing BAM that we have since the vials come separately?**

    Yes.

32. **What about using monoclonals in persons already immunized?**

    This has been done infrequently to my knowledge.

33. **The guide to use of monoclonal antibodies will be in the first 3 days COVID-19 infection with a ct 24 or less, high risk group without lung involvement?**

    As stated in the HCP factsheet, should be given as early as possible and within the first 10 days of symptom onset.

34. **Can we refer a patient for MAb treatment based on rapid antigen test or do we need to wait for PCR?**

    Either test can be used.

35. **Is there any limitation to providing these infusions in the home setting?**

    As stated in the HCP fact sheet, Bamlanivimab and etesevimab may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the emergency medical system (EMS), as necessary.

36. **Some patients have very minimal symptoms. Do you recommend Monoclonal antibody for them? Or should we reserve for patients with more symptoms?**

    Would say that the patient should fall into a high-risk category but should be treated if they have mild-moderate disease.

37. **If a high-risk patient is admitted for reasons other than COVID19, and found to be SARS-COV2 positive on a screening test, is that patient eligible for MAB tx or is test positive date not an adequate marker for determining <10 since infection?**

    Usually through an EIND if they don't fit the EUA requirements.

    We did address this scenario in the public QA. If, for example, an elderly patient is admitted for elective surgery, tests positive for SARS-CoV-2 on a direct test, and has mild to moderate symptoms, treatment with mAbs would be in scope for the authorization.

38. **Combo of the other monoclonals (regreton + one of these)?**

    We do not have data to support this approach at this time.

39. **Great resource from the Allergy/Immunology community on addressing anaphylaxis after mRNA vaccination. mRNA Vaccines to Prevent COVID-19 Disease and Reported Allergic Reactions: Current Evidence and Suggested Approach: https://pubmed.ncbi.nlm.nih.gov/33388478/.**