

Preventing Hospitalization and Outpatient Management

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CDC CORE STRATEGIES



**Stay Up-to-
Date on
Immunizations**



**Practice
Good
Hygiene**



**Take Steps
for Cleaner
Air**



**Stay Home
When Sick**



**Seek Healthcare
When High Risk**

Stay Up-to-Date on Immunizations





Fall and Winter Immunization Guide

COVID-19 and Flu Updated 2024-25 Vaccines

Everyone 6 months
and older



cdc.gov/respiratory-viruses/prevention/immunizations.html

RSV Immunization to Protect Babies

Vaccine

Pregnant parents
during weeks 32-36
of pregnancy during
RSV season

OR

Monoclonal Antibodies
Babies entering or
born during the RSV
season



RSV Vaccine for Older Adults

(currently, older adults only need to get
the RSV vaccine once; not annually)

People ages 60 and
over at high risk of
severe RSV

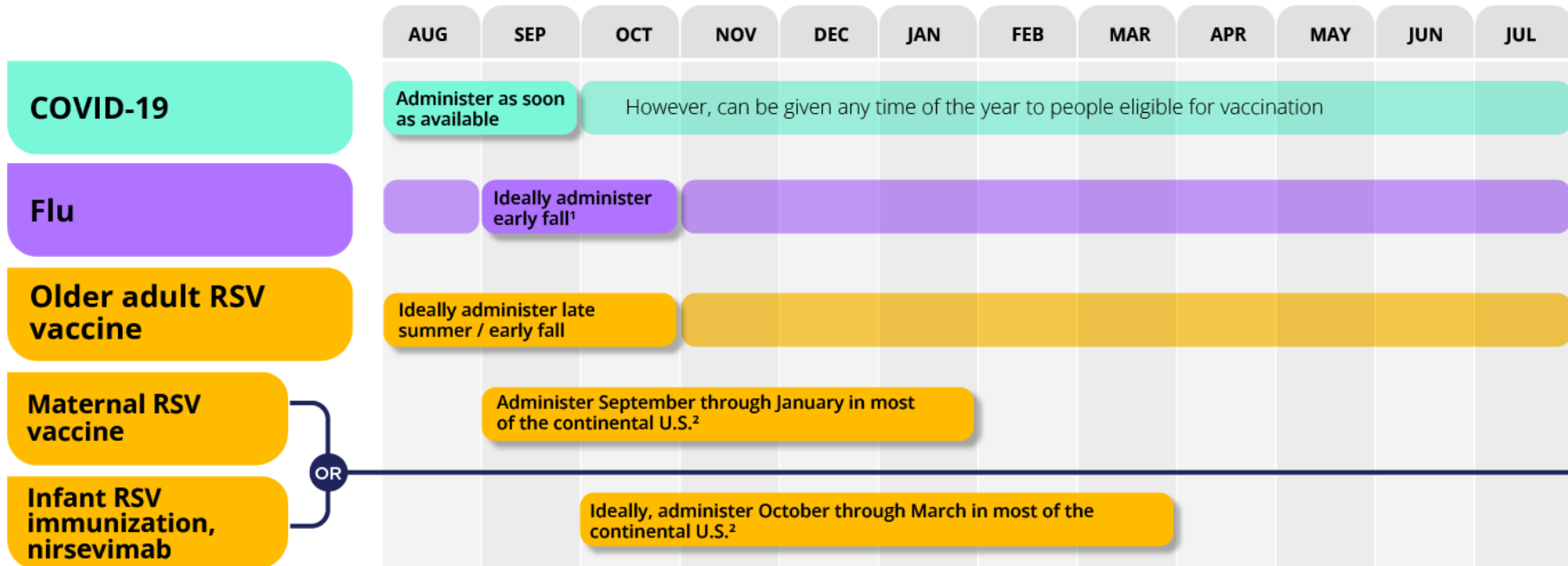
AND

Everyone ages 75
and older





Timing and administration of COVID-19, influenza, and RSV immunizations



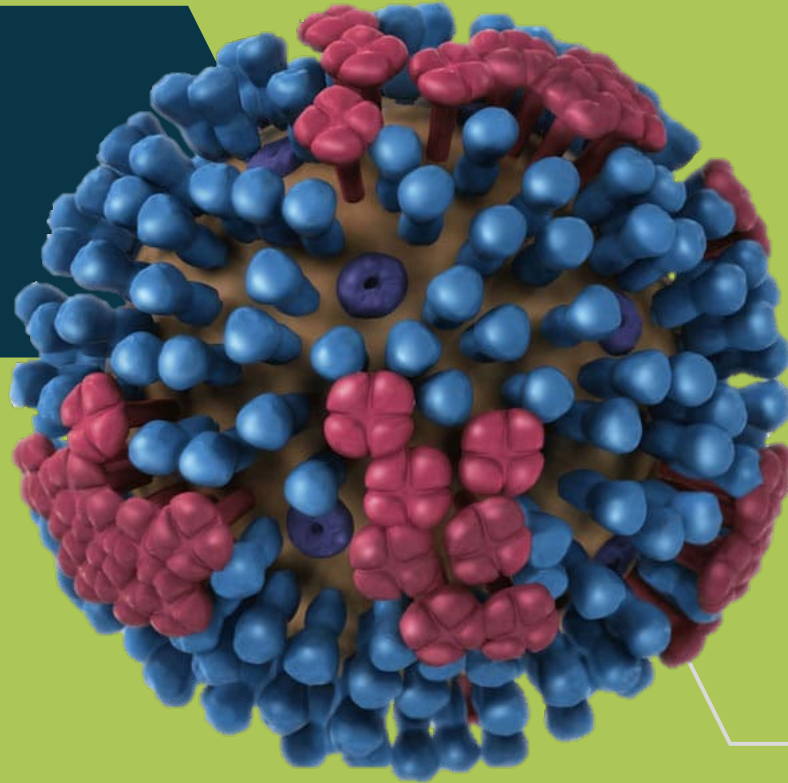
¹ Children who need 2 doses should receive their first dose as soon as possible (including during July and August). One dose of flu vaccine can be considered for pregnant people in their third trimester during July and August.

² In jurisdictions with RSV seasonality that differs from most of the continental United States, including Alaska, southern Florida, Guam, Hawaii, Puerto Rico, U.S.-affiliated Pacific Islands, and U.S. Virgin Islands, providers should follow state, local, or territorial guidance. However, nirsevimab may be administered outside of routine seasonal administration (ie., October through March) based on local RSV activity and other special circumstances. For infants born during October through March, nirsevimab should be administered in the first week of life—ideally during the birth hospitalization.

cdc.gov/respiratory-viruses/prevention/immunizations.html



Influenza



Number Needed to Treat (NNT)

- **Number of persons who need to be treated (receive intervention) to prevent additional adverse outcome**

Vaccines for Preventing Influenza in Healthy Individuals

Reduces the risk of influenza and influenza-like illness



Benefits in NNT

71	NNT of 71 for preventing influenza
29, 5	NNT of 29 for elderly and 5 for children
29	NNT of 29 for preventing influenza-like illness
42, 12	NNT of 42 for elderly and 12 for children



Harms in NNT

125	1 in 125 experienced fever after vaccination
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Source

[Demicheli V, Jefferson T, Ferroni E, Rivetti A, Di Pietrantonj C. Vaccines for preventing influenza in healthy adults. Cochrane Database of Systematic Reviews 2018, Issue 2, Art. No.: CD001269](#)

Study Population: More than 80,000 healthy adults from 52 clinical trials aged 16 to 65 years, including pregnant women, over a single influenza season in North America, South America, and Europe who received vaccination between 1969 and 2009



Influenza Vaccination

Offered Starting September/October and continue while circulating

Adults 65 and older should get high dose, adjuvanted or recombinant vaccinations

Pregnant women should be vaccinated

Per ACIP, people with egg allergy can receive any age-appropriate influenza vaccine

Respiratory Syncytial Virus (RSV)

**EACH
YEAR**

RSV

causes
serious illness
in older adults

100,000–160,000
hospitalizations

RSV is the

LEADING CAUSE

of infant
hospitalization
in the U.S.

RSV Vaccinations for Infants and Children

All young infants should be protected against severe RSV disease through one of the following:

- Vaccination of pregnant people 32 through 36 weeks gestation (Pfizer Abrysvo® only) from September through January
- Immunization of infants <8 months born during or who are entering their first RSV season with nirsevimab, a monoclonal antibody

Some children aged 8 through 19 months at increased risk for severe RSV should receive nirsevimab when entering their second RSV season

RSV Vaccination s for Adults

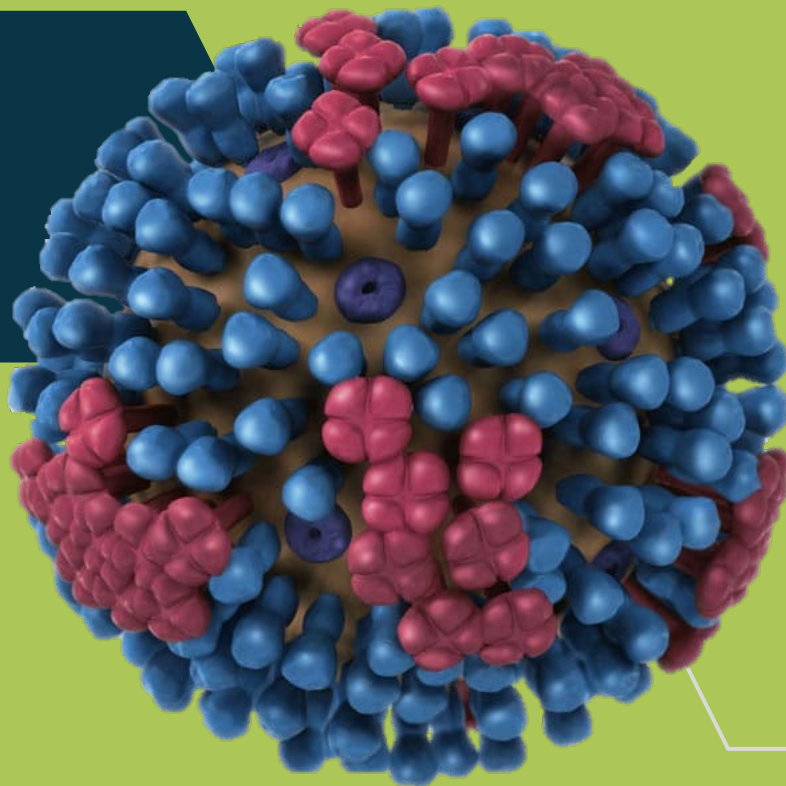
Everyone 75 years of age and older should receive RSV vaccination if they haven't been previously vaccinated

Adults 60 through 74 years of age with certain medical conditions that increase their risk for severe RSV disease should receive RSV vaccination if they haven't been previously vaccinated

RSV Risk Factors for Adults

- Among community-dwelling adults aged ≥ 50 years, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), severe obesity (body mass index [BMI] ≥ 40 kg/m²), asthma, diabetes mellitus, and current smoking were associated with an increased incidence of RSV-associated hospitalization (adjusted incidence rate ratio >1.0), compared with adults who did not have each condition.
- Heart failure and immune compromise, particularly in the setting of lung transplant or hematopoietic cell transplant. Persons living in nursing homes and other long-term care facilities also experience increased risk of severe RSV disease, with RSV frequently causing large outbreaks of respiratory illness in these settings.^{5,6a}
- History of ≥ 2 chronic medical conditions and age ≥ 75 years were independent risk factors for RSV-associated hospitalization

COVID-19



COVID-19 Vaccinations

- Everyone 6 months and older should get the current COVID-19 vaccine
- Vaccination decreases illness severity, hospitalization, and death
- Getting the 2024-2025 vaccine is especially important if you:
 - Have never received a COVID-19 Vaccine
 - Are aged 65+
 - Are age high risk for severe COVID-19
 - Are living in a long-term care facility
 - Are pregnant, breastfeeding, trying to become pregnant, or might become pregnant in the future
 - Want to lower your risk of getting Long COVID

Good Hygiene



Good Hygiene

Washing

Can reduce
respiratory illness
by 16%-21%

Hand Sanitizer

Should be at
least 60%
alcohol

Clean and Disinfect High Touch Surfaces

Follow manufacturer's
directions to ensure
sufficient contact time
for disinfectants

Cover Coughs and Sneezes

Discard tissue in
trash and wash
hands

Clean Air



Clean Air

- Improve air circulation
- Set HVAC fan to on (instead of automatic on/off) when visitors are present
 - Use and change filters every 3 months, or in accordance with manufacturer's instructions
- HEPA cleaner
- Consider having gathering outdoors

Additional Prevention Strategies



- **Wear a well-fitting mask to reduce exposures**
- **Avoid crowds to minimize exposures in public places, particularly indoors**

Other Prevention/Mitigation Measures for Patients

- **Good nutrition and hydration**
- **Achieve/maintain a healthy weight and stay physically active**
- **Manage stress**
- **Get plenty of sleep**
- **Avoid touching eyes, nose, and mouth**

What to Do When You or Your Patients Are Sick



What to Do When You or Your Patients Are Sick

01

Protect
others by
staying home

02

Distance
yourself from
others

03

Wear a mask
when around
others

04

Wash/sanitize
your hands
regularly

When to Seek Urgent/Emergent Medical Care

- **Difficulty breathing or shortness of breath**
- **Persistent pain or pressure in chest or abdomen**
- **Persistent dizziness, confusion, altered mental**

- **Severe dehydration or lack of urination**
- **Severe muscle pain**
- **Severe weakness or unsteadiness**
- **Worsening symptoms**
- **Recurrent fever or cough**

Additionally, in children:

- **Fast breathing or trouble breathing**
- **Bluish lips or face**
- **Intercostal retractions**
- **Fever >104°F or any fever in children < 12 weeks of age**

Treatment Considerations



Influenza Treatment

Neuraminidase Inhibitors For Treatment of Influenza

May reduce duration of symptoms by <1 day but associated with adverse events



Benefits in NNT

	Shorter duration of symptoms by <1 day (14-17 hours) in adults treated with neuraminidase inhibitors compared to placebo
	No reduction in hospitalization or disease complication (e.g. pneumonia)



Harms in NNT

28	1 in 28 adults were harmed (nausea)
22	1 in 22 adults were harmed (vomiting)
19	1 in 19 children were harmed (vomiting)

Source

[Jefferson T, Jones MA, Doshi P, et al. Neuraminidase inhibitors for preventing and treating influenza in healthy adults and children. Cochrane Database Syst Rev. 2014;\(4\):CD008965.](#)

Study Population: Treatment: Adults and children with confirmed or suspected to have influenza and also those with confirmed or possible exposure to influenza

<https://thennt.com/nnt/neuraminidase-inhibitors-treatment-influenza/#>

Risk Factors for Severe Flu

- Adults aged 65+
- Children <5 years (especially <2 years)
- BMI $\geq$ 40
- <19 years old on long-term aspirin or salicylate-containing medications
- Pregnant through 2 weeks postpartum
- Live in long-term care facility
- Weakened immune system due to disease or medication
- Chronic medical conditions (asthma, neurologic/neurodevelopmental condition, blood disorder, chronic lung disease, endocrine disorder, heart disease, kidney disease, liver disorder, metabolic disorders, stroke)

Influenza Treatment Considerations

Treatment

IV. Which patients with suspected or confirmed influenza should be treated with antivirals?

Recommendations

18. Clinicians should start antiviral treatment as soon as possible for adults and children with documented or suspected influenza, irrespective of influenza vaccination history, who meet the following criteria:
- Persons of any age who are hospitalized with influenza, regardless of illness duration prior to hospitalization (A-II).
 - Outpatients of any age with severe or progressive illness, regardless of illness duration (A-III).
 - Outpatients who are at high risk of complications from influenza, including those with chronic medical conditions and immunocompromised patients (A-II).
 - Children younger than 2 years and adults ≥ 65 years (A-III).
 - Pregnant women and those within 2 weeks postpartum (A-III).

Influenza Treatment Considerations

19. Clinicians can consider antiviral treatment for adults and children who are not at high risk of influenza complications, with documented or suspected influenza, irrespective of influenza vaccination history, who are either:
- Outpatients with illness onset ≤ 2 days before presentation (C-I).
 - Symptomatic outpatients who are household contacts of persons who are at high risk of developing complications from influenza, particularly those who are severely immunocompromised (C-III).
 - Symptomatic healthcare providers who care for patients who are at high risk of developing complications from influenza, particularly those who are severely immunocompromised (C-III).

Influenza Treatment Duration

V. For patients who are recommended to receive antiviral treatment for suspected or confirmed influenza, which antiviral should be prescribed, at what dosing, and for what duration?

Recommendations

20. Clinicians should start antiviral treatment as soon as possible with a single neuraminidase inhibitor (NAI) (either oral oseltamivir, inhaled zanamivir, or intravenous peramivir) and not use a combination of NAIs (A-I).
21. Clinicians should not routinely use higher doses of US Food and Drug Administration–approved NAI drugs for the treatment of seasonal influenza (A-III).
22. Clinicians should treat uncomplicated influenza in otherwise healthy ambulatory patients for 5 days with oral oseltamivir or inhaled zanamivir, or a single dose of intravenous peramivir (A-I).
23. Clinicians can consider longer duration of antiviral treatment for patients with a documented or suspected immunocompromising condition or patients requiring hospitalization for severe lower respiratory tract disease (especially pneumonia or acute respiratory distress syndrome [ARDS]), as influenza viral replication is often protracted (C-III).

Influenza Chemoprophylaxis

- Not generally recommended for routine or widespread chemoprophylaxis outside institutional outbreaks, but can be considered in certain situations
- Ideally within 48 hours of exposure
- Neuraminidase inhibitors are effective at preventing influenza

Influenza Treatment Options

Table 1. Antiviral Medications Recommended for Treatment and Chemoprophylaxis of Influenza

Antiviral Agent	Activity Against	Use	Recommended For	Not Recommended for Use in	Adverse Events
Oral Oseltamivir	Influenza A and B	Treatment	Any age ¹	N/A	Adverse events: nausea, vomiting, headache. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events ²
		Chemoprophylaxis	3 months and older ¹	N/A	
Inhaled Zanamivir	Influenza A and B	Treatment	7 yrs and older ³	People with underlying respiratory disease (e.g., asthma, COPD) ³	Adverse events: risk of bronchospasm, especially in the setting of underlying airways disease; sinusitis, and dizziness. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events ²
		Chemoprophylaxis	5 yrs and older ³	People with underlying respiratory disease (e.g., asthma, COPD) ³	
Intravenous Peramivir	Influenza A and B ⁴	Treatment	6 months and older ⁴	N/A	Adverse events: diarrhea. Post marketing reports of serious skin reactions and sporadic, transient neuropsychiatric events ²
		Chemoprophylaxis ⁵	Not recommended	N/A	
Oral Baloxavir	Influenza A and B ⁶	Treatment	5 yrs and older ⁶	N/A	Adverse events: none more common than placebo in clinical trials
		Chemoprophylaxis ⁶	Approved for post-exposure prophylaxis in persons 5 yrs and older ⁶		

Influenza Treatment Options

Table 2. Recommended Dosage and Duration of Influenza Antiviral Medications for Treatment or Chemoprophylaxis

Antiviral Agent	Use	Children	Adults
Oral Oseltamivir	Treatment (5 days) ¹	If younger than 1 yr old ² : 3 mg/kg/dose twice daily ^{1,4} If 1 yr or older, dose varies by child's weight: 15 kg or less, the dose is 30 mg twice a day >15 to 23 kg, the dose is 45 mg twice a day >23 to 40 kg, the dose is 60 mg twice a day >40 kg, the dose is 75 mg twice a day	75 mg twice daily
	Chemoprophylaxis (7 days) ³	If child is younger than 3 months old, use of oseltamivir for chemoprophylaxis is not recommended unless situation is judged critical due to limited data in this age group. If child is 3 months or older and younger than 1 yr old ² 3 mg/kg/dose once daily ³ If 1 yr or older, dose varies by child's weight: 15 kg or less, the dose is 30 mg once a day >15 to 23 kg, the dose is 45 mg once a day >23 to 40 kg, the dose is 60 mg once a day >40 kg, the dose is 75 mg once a day	75 mg once daily
Inhaled Zanamivir ⁴	Treatment (5 days)	10 mg (two 5-mg inhalations) twice daily (FDA approved and recommended for use in children 7 yrs or older)	10 mg (two 5-mg inhalations) twice daily
	Chemoprophylaxis (7 days) ⁵	10 mg (two 5-mg inhalations) once daily (FDA approved for and recommended for use in children 5 yrs or older)	10 mg (two 5-mg inhalations) once daily
Intravenous Peramivir ⁷	Treatment (1 day) ¹	(6 months to 12 yrs of age) One 12 mg/kg dose, up to 600 mg maximum, via intravenous infusion for a minimum of 15 minutes (FDA approved and recommended for use in children 6 months or older)	(13 yrs and older) One 600 mg dose, via intravenous infusion for a minimum of 15 minutes
	Chemoprophylaxis ⁸	Not recommended	N/A

Table 2. Recommended Dosage and Duration of Influenza Antiviral Medications for Treatment or Chemoprophylaxis

Oral Baloxavir ⁹	Treatment (1 day)	(5 yrs and older weighing <20 kg: single dose of 2 mg/kg by suspension; weighing 20 kg to <80 kg: single dose of 40 mg by tablet or suspension; weighing ≥80 kg: single dose of 80 mg by tablet or suspension) FDA approved and recommended for use in otherwise healthy children 5 yrs and older.	Weight <80 kg: One 40 mg dose; Weight ≥80 kg: One 80 mg dose ⁹
	Chemoprophylaxis ⁹	FDA approved for post-exposure prophylaxis for persons aged 5 years and older. Dosage is the same as for treatment.	Dosage is the same as for treatment

RSV Treatment

- Primarily supportive

COVID-19 Treatment

Hydroxychloroquine/Chloroquine + Azithromycin

- **Recommendation 1:** Among patients with COVID-19, the IDSA guideline panel **recommends against** hydroxychloroquine. (Strong recommendation, Moderate certainty of evidence)
 - **Remark:** Chloroquine is considered to be class equivalent to hydroxychloroquine.
- **Recommendation 2:** Among hospitalized patients with COVID-19, the IDSA guideline panel **recommends against** hydroxychloroquine plus azithromycin. (Strong recommendation, Low certainty of evidence)
 - **Remark:** Chloroquine is considered to be class equivalent to hydroxychloroquine

COVID-19 Treatment

Lopinavir/Ritonavir

- **Recommendation 4:** In persons exposed to COVID-19, the IDSA guideline panel **recommends against** post-exposure prophylaxis with lopinavir/ritonavir. (Strong recommendation, Moderate certainty of evidence)
- **Recommendation 5:** Among ambulatory patients with mild-to-moderate COVID-19, the IDSA guideline panel **recommends against** the use of lopinavir/ritonavir. (Strong recommendation, Moderate certainty of evidence)
- **Recommendation 6:** Among hospitalized patients with COVID-19, the IDSA guideline panel **recommends against** the use of the combination lopinavir/ritonavir. (Strong recommendation, Moderate certainty of evidence)

COVID-19 Treatment

Glucocorticoids

- **Recommendation 7:** Among hospitalized critically ill patients* with COVID-19, the IDSA guideline panel **recommends** dexamethasone rather than no dexamethasone. (Strong recommendation, Moderate certainty of evidence)
 - **Remark:** If dexamethasone is unavailable, equivalent total daily doses of alternative glucocorticoids may be used. Dexamethasone 6 mg IV or PO for 10 days (or until discharge) or equivalent glucocorticoid dose may be substituted if dexamethasone is unavailable. Equivalent total daily doses of alternative glucocorticoids to dexamethasone 6 mg daily are methylprednisolone 32 mg and prednisone 40 mg.

COVID-19 Treatment

Glucocorticoids

- **Recommendation 8:** Among hospitalized patients with severe**, but non-critical, COVID-19, the IDSA guideline panel **suggests** dexamethasone rather than no dexamethasone. (Conditional recommendation†, Moderate certainty of evidence)
 - **Remark:** Dexamethasone 6 mg IV or PO for 10 days (or until discharge) or equivalent glucocorticoid dose may be substituted if dexamethasone is unavailable. Equivalent total daily doses of alternative glucocorticoids to dexamethasone 6 mg daily are methylprednisolone 32 mg and prednisone 40 mg.

COVID-19 Treatment

Glucocorticoids

- **Recommendation 9:** Among hospitalized patients with mild-to-moderate*** COVID-19 without hypoxemia requiring supplemental oxygen, the IDSA guideline panel **suggests against** the use of glucocorticoids. (Conditional recommendation††, Low certainty of evidence)

COVID-19 Treatment

Inhaled Corticosteroids

- **Recommendation 10:** Among ambulatory patients with mild-to-moderate COVID-19, the IDSA guideline panel **suggests against** inhaled corticosteroids. (Conditional recommendation^{††}, Moderate certainty of evidence)
 - **Remark:** Patients who are on inhaled corticosteroids for other indications may continue them.
- ^{††}*The guideline panel concluded that the undesirable effects outweigh the desirable effects, though uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

COVID-19 Treatment

Remdesivir

- **Recommendation 16:** Among patients (ambulatory or hospitalized) with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel **suggests** remdesivir initiated within seven days of symptom onset rather than no remdesivir. (Conditional recommendation†, Low certainty of evidence)
 - **Remarks:**
 - Dosing for remdesivir in mild-to-moderate COVID-19 is 200 mg on day one followed by 100 mg on days two and three. Pediatric dosing is 5 mg/kg on day 1 and 2.5 mg/kg on subsequent days.
 - Options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, three-day treatment with remdesivir, molnupiravir, and neutralizing monoclonal antibodies. Patient-specific factors (e.g., patient age, symptom duration, renal function, drug interactions), product availability, and institutional capacity and infrastructure should drive decision-making regarding choice of agent. Data for combination treatment do not exist in this setting.

COVID-19 Treatment

Remdesivir

- **Recommendation 17:** In patients on supplemental oxygen but not on mechanical ventilation or ECMO, the IDSA panel **suggests** treatment with five days of remdesivir rather than 10 days of remdesivir. (Conditional recommendation†, Low certainty of evidence)
- **Recommendation 18a:** In hospitalized patients with severe* COVID-19, the IDSA panel **suggests** remdesivir over no antiviral treatment. (Conditional recommendation†, Moderate certainty of evidence)
- **Recommendation 18b:** In patients with COVID-19 on invasive ventilation and/or ECMO, the IDSA panel **suggests against** the routine initiation of remdesivir (Conditional recommendation††, Very low certainty of evidence)

COVID-19 Treatment

Ivermectin

- **Recommendation 24:** In hospitalized patients with COVID-19, the IDSA panel **suggests against** ivermectin. (Conditional recommendation^{††}, Very low certainty of evidence)
- **Recommendation 25:** In ambulatory persons with COVID-19, the IDSA panel **recommends against** ivermectin. (Strong recommendation, Moderate certainty of evidence)
- ^{††}*The guideline panel concluded that the undesirable effects outweigh the desirable effects, though uncertainty still exists, and most informed people would choose the suggested course of action, while a substantial number would not.*

COVID-19 Treatment

Nirmatrelvir/Ritonavir

- **Recommendation 27(UPDATED 4/12/2023):** In ambulatory patients with mild-to-moderate COVID-19 at high risk for progression to severe disease, the IDSA guideline panel **suggests** nirmatrelvir/ritonavir initiated within five days of symptom onset rather than no nirmatrelvir/ritonavir. (Conditional recommendation†, Low certainty of evidence)
 - **Remarks:**
 - Patients' medications need to be screened for serious drug interactions
 - Dosing based on renal function:
 - Estimated glomerular filtration rate (eGFR) > 60 mL/min: 300 mg nirmatrelvir/100 ritonavir every 12 hours for five days
 - eGFR ≤60 mL/min and ≥30 mL/min: 150 mg nirmatrelvir/100 mg ritonavir every 12 hours for five days
 - eGFR <30 mL/min: not recommended
 - Patients with mild-to-moderate COVID-19 who are at high risk of progression to severe disease admitted to the hospital may also receive nirmatrelvir/ritonavir
 - *Options for treatment and management of ambulatory patients include nirmatrelvir/ritonavir, remdesivir for a 3-day course, molnupiravir, and neutralizing monoclonal antibodies. Patient-specific factors (e.g., symptom duration, renal function, drug interactions) as well as product availability should drive decision-making regarding choice of agent. Data for combination treatment do not exist in this setting*

COVID-19 Treatment

Molnupiravir

- **Recommendation 28:** In ambulatory patients (≥ 18 years) with mild-to-moderate COVID-19 at high risk for progression to severe disease who have no other treatment options*, the IDSA guideline panel **suggests** molnupiravir initiated within five days of symptom onset rather than no molnupiravir. (Conditional recommendation†, Low certainty of evidence)
- Molnupiravir is **not authorized** under the FDA EUA for use in patients < 18 years because it may affect bone and cartilage growth.
- Molnupiravir is **not recommended** under the FDA EUA for use during pregnancy

COVID-19 Treatment

Colchicine

- **Recommendation 29:** In hospitalized patients with COVID-19, the IDSA panel **recommends against** colchicine for treatment of COVID-19. (Strong recommendation, Moderate certainty of evidence)
- **Recommendation 30:** In ambulatory persons with COVID-19, the IDSA panel **suggests against** colchicine for treatment of COVID-19. (Conditional recommendation^{††}, Moderate certainty of evidence)

COVID-19 Treatment

Azithromycin for Treatment of COVID-19

Azithromycin for Treatment of COVID-19 does not reduce mortality or improve clinical outcomes



Benefits in NNT

No inpatients or outpatients with COVID-19 were helped (azithromycin [Zithromax] vs. standard of care or placebo)



Harms in NNT

No one was harmed

Source

[Echeverría-Esnal D, Martín-Ontivero C, Navarrete-Rouco ME, et al. Azithromycin in the treatment of COVID-19: a review. Expert Rev Anti Infect Ther. 2021;19\(2\):147-163.](#)

Study Population: 9,049 patients hospitalized with COVID-19 (inpatient setting) and 1,917 patients not hospitalized with COVID-19 (outpatient setting)

Efficacy Endpoints

For patients who were hospitalized: all-cause mortality, clinical status (worsening or improvement), and death within 28 days of diagnosis; for patients not hospitalized: all-cause mortality, hospital admission, death within 28 days of diagnosis, and symptom resolution within 14 days

Harm Endpoints

Any adverse events and serious adverse events

Treatment options for COVID-19

Treatment	Who	Route	Duration	Time from Illness Onset	Specific Issues
Nirmatrelvir-Ritonavir (Paxlovid) 	Adults; children aged 12 years and older and at least 40kg	Oral	5 days	≤5 days	Adjust dosing in some cases; drug-drug interactions  ; severe kidney and liver contraindications; no specific testing required before initiation
Remdesivir (Veklury)  	Adults; children aged 28 days and older and at least 3kg	Intravenous	3 days	≤7 days	Infusion over 30-120 minutes; infusion over 3 consecutive days; need to check liver function and prothrombin time before initiation
<i>Recommended to use if above medications cannot be used or are unavailable.</i>					
Molnupiravir (Lagrevio) 	Adults	Oral	5 days	≤5 days	Women who are able to become pregnant and their partners should use birth control; avoid in pregnant women; no specific testing required before initiation

COVID-19 Pre-Exposure Prophylaxis

Pemgarda (pemivibart)

- Monoclonal antibody
- EUA authorization for pre-exposure prophylaxis in adolescents and adults who:
 - ✓ Are not currently infected with COVID-19 and have not had recent exposure to COVID-19 **AND**
 - ✓ Are moderately-to-severely immunocompromised and are unlikely to mount an adequate response to COVID-19 vaccination
- Single IV infusion over 60 minutes in a healthcare facility
- Protection lasts 3 months
- Does not replace vaccination

<https://www.cdc.gov/covid/hcp/clinical-care/outpatient-treatment.html>

Return to Regular Activities

Patients can return to normal activities when, for at least 24 hours, both are true:

- Symptoms are improving overall AND
- No fever (without the use of fever-reducing medication)

Testing Considerations



Testing Considerations

- Testing is an important part of deciding on treatment, symptom management and infection control
- Antigen tests may produce false negative results early in illness; false positive results are less common
- Co-infections and secondary infections can occur

**Other
Potential
Viral
Respirato
ry
Infection**

**Adenoviru
s**

**Rhinoviru
s/Entero
virus**

**Parvovirus
B19 (Fifth's
Disease)**

**Parainflue
nza**

**Human
Metapneu
movirus
(hMPV)**

**Human
Coronaviru
s 229E,
NL63,
OC43,
HKU1**

***Haemophilu
s influenzae
(invasive)***

**Pertuss
is**

Hantavirus

**Tuberculo
sis**

**Coccidioidomyco
sis**

**Legionello
sis**

**Other
Reportab
le
Non-viral
Respirato**

Respiratory Virus Guidance Snapshot



Core Prevention Strategies

Immunizations



Hygiene



Steps for Cleaner Air



Treatment



Stay Home and Prevent Spread*



Additional Prevention Strategies

Masks



Distancing



Tests



Layering prevention strategies can be especially helpful when:

- ✓ Respiratory viruses are causing a lot of illness in your community
- ✓ You or those around you have risk factors for severe illness
- ✓ You or those around you were recently exposed, are sick, or are recovering

*Stay home and away from others until,



and



Your symptoms are
getting better

You are fever-free
(without meds)

for 24 hrs



Then take added precaution
for the next 5 days



Call to Action

- Health care providers are the most trusted source of health information for their patients
- Immunizations and early clinical intervention can protect against hospitalizations, long-term health impacts, and death
- All patients should receive education on prevention and mitigation measures
- Consider providing additional education and stronger recommendations for patients at high risk