NHS
North East London

Guideline for treatment of COVID-19 in North East London ICS

Document control	
Version	6
Previous version history	**Version 6 update (June 2026):** - discontinuation of Sotrovimab with amendment to treatment guidelines - appendix 3 on reimbursement mechanism for COVID-19 treatments - change to service provision for non-hospitalised patients, including new referral details - minor editorial refinement made throughout document, removal of dated links
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Background

From the 1st April 2023, the commissioning responsibility for all COVID-19 treatments was transferred from NHS England to Integrated Care Boards (ICBs). Below are the latest NICE technology appraisals and guidelines that were used in the COVID guidance.

- NICE TA878 Nirmatrelvir plus ritonavir (Paxlovid), sotrovimab and tocilizumab for treating COVID-19. Published 29/3/24 this confirmed their position on Paxlovid use. However, from the 1st May 2025, NICE updated TA878 - Paxlovid, sotrovimab and tocilizumab for treating COVID-19 in adults (for people with diabetes, obesity or heart failure, or aged 70 years or over) that Paxlovid is no longer cost effective for these populations, so the recommendation for these groups has been withdrawn.

- NICE TA 1056 recommends Molnupiravir as an option for treating mild to moderate COVID-19 in adults who have a positive SARS-CoV-2 test only if they have 1 or more risk factors for progression to severe COVID-19 as defined here and 1st treatment is contraindicated or unsuitable. This should be considered only in the community setting for people with mild to moderate COVID-19 who are at risk of developing severe COVID-19 and cannot have Paxlovid,. This does not include everyone it is licensed for.

- NICE TA971 was released in May 2024; this technology appraisal reviews the use of remdesivir and tixagevimab plus cilgavimab. Tixagevimab plus cilgavimab is not a recommended treatment and will not feature as part of this guideline. Remdesivir is recommended in hospital patients only.

- NICE NG191 COVID-19 rapid guideline: managing COVID-19 summarises and outlines all therapies recommended by NICE for treatment of COVID-19. In May 2025 NICE updated the recommendation on Paxlovid in line with NICE's technology appraisal guidance on Paxlovid, sotrovimab and tocilizumab for treating COVID-19. Because of a change to the company's list price, this treatment combination is now only recommended

for people at increased risk of progression to severe COVID-19. For full details, see the update information section of the technology appraisal guidance.

- The use of Paxlovid between 12-18 years is unlicensed. An application for its use in this cohort within CMDU services was submitted and approved by NEL FPG and IMOC in December 2023.This was later extended to inpatient use in NEL hospitals. Inpatients aged 12-18 years being considered for Paxlovid should also be discussed with Paediatric infectious diseases medical team (inpatients).

- Baricitinib does not have a licence for the use of treatment in COVID -19 and is therefore an off-label use. For this reason, it also meant it fell outside of the scope for the NICE MTA878 and could not be included in the recommendations. However, NHS England wrote to all ICB Medical Directors in April 2023 directing them to a template baricitinib policy in the treatment of patients hospitalised due to COVID-19.

- In January 2026, GSK announced they had ceased the manufacture of Sotrovimab. Once existing stock expired on 28th February 2026, this would no longer be available.

Treatment pathway

A treatment pathway for patients across North East London who have COVID-19 is detailed below. The pathway includes the treatment options available for:
(1) inpatients in a Trust in North East London with COVID-19 who require oxygen
(2) inpatients admitted to a Trust in North East London with COVID-19 who are symptomatic with no oxygen requirement
(3) non-hospitalised patients across North East London with COVID-19 who are symptomatic.

The pathway will include the use of baricitinib, as an off-label agent for COVID-19, and remdesivir and molnupiravir as recommended in NG191.

Inpatients in hospitals in North East London

The following treatment pathways are being recommended for use in North East London.
Appendix 1 contains detailed information about the drug treatments.

(1) Inpatients' with COVID-19 who require supplemental oxygen in a North East London Hospital Trust (Table 1):
- **All** COVID-19 positive patients on oxygen should receive corticosteroids
- Further treatment options are based on the patients' individual clinical criteria.
- Please note that patients may receive multiple therapies as indicated.

(2) Treatment of hospital inpatients with COVID-19 (nosocomial or community onset) in a North East London Trust and not requiring supplemental oxygen (table 2):

First line: Paxlovid
Second line: Remdesivir

At Barts Health the following patients should be discussed with local COVID panel/specialist MDT:
1. If treating clinicians wish to use drug outside of patient eligibility criteria
2. Patients with severe immunosuppression
3. Patients with persistent SARS-CoV-2 RNA detection +/- symptoms

For all actions/decisions outside of the guidance these should be managed through Trust Chairs actions.
(Sarilumab to be used only in the event of tocilizumab shortage.)

Non-hospitalised patients

Appendix 2 (Table 3) contains detailed information about the drug treatments for this cohort of patients.

(1) Non-hospitalised patients across North East London

First line: Paxlovid
Second line: Molnupiravir

Immunocompromised patients

Treatment of severely immunocompromised patients such as those with a bone marrow transplant, CAR-T recipients, solid organ transplant and primary immunodeficiency should be discussed with the specialist MDT or appropriate clinicians within the treating Trust e.g. at Barts Health with COVID drugs panel.

For some immunocompromised patients following discussion with the specialist MDT, dual therapies may be considered as is reviewed in Scoto *et al.* (2023) and Gentile *et al.* (2023). This use falls outside of the NICE commissioned criteria. Local governance procedures should be followed when recommending outside of established criteria such as a Chair's action
Ref:

- Scotto R. Remdesivir Alone or in Combination with Monoclonal Antibodies as an Early Treatment to Prevent Severe COVID-19 in Patients with Mild/Moderate Disease at High Risk of Progression: A Single Centre, Real-Life Study. Vaccines (Basel). 2023 Jan 17;11(2):200.
- Gentile, I., et al. Optimizing COVID-19 treatment in immunocompromised patients: early combination therapy with remdesivir, nirmatrelvir/ritonavir and sotrovimab. Virol J 20, 301 (2023).

Evidence supporting COVID therapies

Paxlovid

When initiated within 5 days of symptom onset, treatment with Paxlovid significantly reduced the incidence of hospitalisation or death by 85.2% through Day 28. No deaths were reported in the Paxlovid group compared with 10 deaths in the placebo group.

Remdesivir

A statistically significant reduced risk of hospitalisation has been shown from the evidence synthesis based on the PINETREE trial, a double-blind randomised controlled trial of remdesivir in the mild COVID 19 [non-hospital] setting, Gottlieb *et al.* (2022).

Beckerman *et al.* (2022), Amstutz *et al.* (2023) and Huang *et al.* (2023) showed a statistically significant 28-day mortality benefit for remdesivir compared with standard care in adults who need low-flow oxygen.

Sotrovimab

Sotrovimab was discontinued on 28th February 2026 therefore unavailable as a treatment option.

Tocilizumab

Compared to standard treatment or placebo, tocilizumab reduced all-cause mortality in all studies and reduced mechanical ventilation and length of stay in RCTs in hospitalized COVID-19 patients.

Data collection

Provider trusts are required to submit Blueteq forms for reporting purposes. This requirement applies only to prescriptions issued for hospitalised patients and does not extend to prescriptions for non-hospitalised patients. Blueteq will be used for verification that a patient meets the clinical and funding eligibility criteria for treatment. However, Blueteq information does not provide support for financial resources and cannot be used to determine budgets, track treatment volumes, or decide or apply any funding limits or caps.

Appendix 3 contains details on the reimbursement mechanism for COVID-19 treatments in hospitalised patients.

References

- NICE NG191 COVID-19 rapid guideline: managing COVID-19 | Guidance | NICE
- NICE TA878 Nirmatrelvir plus ritonavir for treating COVID-19
- NICE TA 971 Remdesivir and tixagevimab plus cilgavimab for treating COVID-19
- NICE TA 1056 Molnupiravir for treating COVID-19

Appendix 1

Further information for Treatment of COVID-19 hospitalised patients

Table 1: Treatment of inpatients with ACUTE COVID-19 who require supplemental oxygen for COVID-19

Patients can be prescribed multiple therapies from this table

Treatment	Corticosteroids All Patients requiring oxygen	Tocilizumab **(IL6 inhibitors, Anti-inflammatory)** Adults only For patients with inflammatory symptoms CRP (>75) or respiratory support no concomitant infection No restriction on duration onset of symptoms	Remdesivir **(Antiviral)** Paediatrics and Adults	Baricitinib **Janus kinase (JAK) inhibitor_ Anti-inflammatory** Paediatrics and Adults Unlicensed Use For patients with inflammatory respiratory support no concomitant infection No restriction on duration onset of symptoms
Eligibility criteria for treatment	• Patient requires supplemental oxygen to meet their prescribed oxygen saturation levels **OR** • Have a level of hypoxia that needs supplemental oxygen but who are unable to have or tolerate it **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients	• SARS-CoV-2 positive by diagnostic PCR or POCT on this hospital admission **AND** • The patient has pneumonitis with saturations <92% on room air requiring: a) supplemental oxygen AND CRP ≥ 75 mg/L; **OR** b) requiring advanced respiratory support (HFNO, CPAP or other non-invasive ventilation or invasive mechanical ventilation) within the last 48 hours, regardless of CRP **AND** • > 18 years of age **AND** • Is receiving a course of dexamethasone or equivalent corticosteroid (unless contraindicated) **AND** • Have not received an IL-6 inhibitor (tocilizumab, sarilumab) during this admission episode	• SARS-CoV-2 positive by diagnostic PCR or POCT on this hospital admission **AND** • Need supplemental oxygen **AND** • Are aged 4 weeks to 17 years **AND** • Weigh at least 3kg **AND** • Have pneumonia **OR** • Aged 4 weeks to 17 years **AND** • who weigh at least 40kg **AND** • Have a high risk of serious illness defined here	• SARS-CoV-2 positive by diagnostic PCR or POCT on this hospital admission **AND** • > 2 years of age[1] **AND** • Receiving supplemental oxygen for the treatment of COVID-19 **AND** • The patient has no evidence of infection (other than SARS-CoV-2) that might be worsened by baricitinib **AND** • Receiving or has received a course of dexamethasone or an equivalent corticosteroid *(unless contraindicated)* **AND** • eGFR >15mL/min/1.73m^2 [if patient is <9 years, eGFR should be >30mL/min/1.73m^2] **AND** • Not receiving dialysis or haemofiltration

		AND • The MDT is confident of a low probability of any active infection other than COVID-19 (consider checking procalcitonin). This includes bacterial superinfection such as HAP, UTI, and cellulitis. **AND** • No known pre-existing condition or treatment resulting in ongoing immunosuppression **AND** • ALT/AST< 10 times upper limit of normal (caution with pre-existing liver disease) **AND** • Platelet count ≥ 50 x 10^9/L **AND** • Neutrophil count ≥ 1 x 10^9/L (caution) **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients. • Note: Baricitinib may be considered in people who meet the above criteria, and who cannot have tocilizumab. When there is clinical deterioration despite treatment with tocilizumab, it may be appropriate to add baricitinib.	**OR** • Adult ≥18years with a high risk of serious illness, as defined here **AND** • Within 10 days of symptom onset *(discuss immunocompromised [2] with specialist MDT*)* **AND** • eGFR >30ml/min (use with caution if GFR <50ml/min, discuss with specialist team* if <30ml/min) ***OR*** • The patient is established on renal replacement therapy (haemo- or peritoneal dialysis) **AND** • ALT < 5 x ULN and NO chronic liver disease (Childs Pugh C) **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients	**AND** • No history of severe hepatic disease **AND** • Absolute neutrophil count (ANC) >0.5 x 10^9 cells/L and haemoglobin >8g/dL **AND** • Patient does not have active tuberculosis. **AND** • Patient is not pregnant or breastfeeding (*women of childbearing potential should use effective contraception during and for at least 1 week after treatment)* **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients. • Note: Baricitinib may be considered in people who meet the above criteria, and who cannot have tocilizumab. When there is clinical deterioration despite treatment with tocilizumab, it may be appropriate to add baricitinib.
Dose and treatment duration	**Dexamethasone** Adult dose: PO 6mg OD or 6mg IV OD (if unable to tolerate PO)(1.8ml of 3.3mg/ml) ***OR*** **Prednisolone** PO 40mg OD ***OR*** **Hydrocortisone succinate** IV 50mg TDS	**Tocilizumab:** Dosing based on weight and stock availability as per table in microguide Total treatment duration: **STAT dose ONLY** **Tocilizumab biosimilar should be used in preference where available. Refer to local pharmacy for the current cost-effective brand. The originator brand (RoActemra)**	**Remdesivir** **Children aged 4 weeks old to 17 years old with a weight of 3kg to 39kg** : Remdesivir STAT 5mg/kg IV followed by 2.5mg/kg each day Duration: **total of 10 days** **Children 4 weeks old -17 years old with weight over 40kg and ADULTS :**	**Baricitinib[2]**

<table>
<tr>
<td></td>
<td>Total treatment duration up to 10 days

Continue corticosteroids for up to 10 days unless there is a clear indication to stop early, which includes discharge from hospital or a hospital-supervised virtual COVID ward.

For paediatric doses see here</td>
<td>should only be used where biosimilars are unavailable or unsuitable.</td>
<td>Day 1: 200mg OD
Day 2 onwards: 100mg OD

Duration: for total 5 days
(immunocompromised [3]patients can be treated for up to 10 days)</td>
<td>
<table>
<tr><th></th><th>eGFR >60mL/ min</th><th>eGFR ≥30 to <60 mL/min</th><th>eGFR 15 to <30mL/min</th></tr>
<tr><td>≥ 9 years old and adults</td><td>4mg OD</td><td>2mg OD</td><td>2mg on alternate days</td></tr>
<tr><td>Children 2 to <9 years old</td><td>2mg OD</td><td>2mg on alternate days</td><td>avoid</td></tr>
</table>
Co-administration of an Organic Anion Transporter 3 (OAT3) inhibitor with a strong inhibition potential e.g., probenecid – Dose reduced to Baricitinib PO 2mg OD

Total treatment duration: 10 days (or until discharge if sooner)
</td>
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<tr>
<td>Approval form</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</table>

[1] Baricitinib can be considered in children (age 2 to 17 years inclusive) with severe COVID-19, guided by clinical judgement and multi-disciplinary team assessment.
[2] Refers to patients with a significant impairment of humoral immune response (antibody production) and/or cellular immune competence.

POCT= Point of care test e.g. lateral flow

Note: where it is stated ‘At an increased risk of progression to severe COVID-19, this links to the following website: https://www.nice.org.uk/guidance/ta878/chapter/supporting-information-on-risk-factors-for-progression-to-severe-covid19#supporting-information-on-risk-factors-for-progression-to-severe-covid19 and see NICE TA878 for Box 2 Risk factors for progression to severe COVID-19 in young people aged 12 to 17 years

Table 2: Treatment of inpatients who have COVID-19 without requiring supplemental oxygen for COVID-19

Therapy should be selected in order of recommendations e.g. if first line not suitable, review if the second line option is suitable etc.

Treatment	Paxlovid (nirmatrelvir plus ritonavir) First Line	Remdesivir Second line
Eligibility criteria for treatment	• The patient does not need supplemental oxygen for COVID-19 (may need oxygen for other conditions.) **AND** • Confirmed by PCR or POCT. **AND** • Symptomatic with COVID-19 **AND** **Are any of the following:** • At an increased risk of progression to severe COVID-19, as defined here **OR / AND** • ≥12 years of age and ≥40kg [3] **AND** • Treatment is commenced within 5 days of symptom onset **AND** • No history of severe renal or liver disease. These patients require their treatment to be discussed with the specialist clinical team*. **AND** • Pregnancy has been excluded in women of childbearing age. Breast-feeding should be discontinued during treatment and for 7 days after last dose. **AND** • Deemed safe after assessing potential drug interactions. Please note there are numerous significant drug interactions associated with Paxlovid. **AND**	• Confirmed by PCR or POCT **AND** • The patient does not need supplemental oxygen for COVID-19, however (may need oxygen for other conditions). **AND** • The patient is ≥18 years old **OR** • The patient is 4 weeks to 17 years old and weighs at least 40kg **AND** • The patient has a high risk of serious illness as defined here (link) **AND** • Is within 7 days of symptom onset *(discuss immunocompromised patients with specialist* team)* **AND** • ALT < 5 x ULN and NO history of chronic liver disease **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients **AND** • Treatment with Paxlovid is contraindicated or not possible **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients **AND** • eGFR >30ml/min (use with caution if GFR <50ml/min, discuss with specialist team if <30ml/min*) ***OR*** • The patient is established on renal replacement therapy (haemo- or peritoneal dialysis)

	• Patient does not require hospital-level care for the management of acute COVID-19 **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients, or drug interactions (link) **Note**: If there are significant drug interactions present between Paxlovid and the patient's current medication regimen (e.g. after review with a Pharmacist it is not possible to be resolved through dose amendments), please consider 2nd line treatment options. If Paxlovid is the most appropriate treatment of choice, please contact the respective specialist team for further advice on the management of the drug interactions.	
Dose and Treatment Duration	**Paxlovid (nirmatrelvir plus ritonavir)** **Patients with eGFR >60ml/min:** 300mg (2x150mg nirmatrelvir tabs) PO with 100mg (1x100mg ritonavir tab) PO BD for 5 days. **For patients with eGFR ≥30ml/min – 60ml/min**: 150mg (1x150mg nirmatrelvir tabs) PO with 100mg (1x100mg ritonavir) PO BD for 5 days Discuss patients with eGFR<30ml/min with specialist team*. Total treatment duration: **5 days**	**Remdesivir** **Children under 17 years old with weight over 40kg and ADULTS :** Day 1: 200mg OD Day 2 onwards: 100mg OD Total treatment duration: **total 3 days**
Approval form	Yes	Yes

[1] Baricitinib can be considered in children (age 2 to 17 years inclusive) with severe COVID-19, guided by clinical judgement and multi-disciplinary team assessment.
[2] Refers to patients with a significant impairment of humoral immune response (antibody production) and/or cellular immune competence.
[3]The use of Paxlovid between 12-18 years is unlicensed. An application for its use in this cohort within CMDU services was submitted to NEL FPG and IMOC in December 2023 and was approved. Patients aged 12–18 years are referred to the Barts Health COVID service, where they are triaged by the CMDU pharmacist. Treatment is supplied where eligibility criteria are met. If patients are not eligible for treatment, they are referred back to their GP, or advised to seek urgent medical attention if clinically unwell.

Use of Paxlovid in aged 12-18 years is now extended to inpatients in this FPG application. Inpatients aged 12-18 years being considered for Paxlovid should also be discussed with Paediatric infectious diseases medical team (inpatients). See also NICE TA878 for Box 2 Risk factors for progression to severe COVID-19 in young people aged 12 to 17 years

Reference information: National guidance for the management of children in hospital with viral respiratory tract infections (2023) | RCPCH

Notes:

- The following patients should be discussed with local COVID panel/specialist MDT*.
  1. If treating clinicians wish to use drug outside of patient eligibility criteria
  2. Patients with severe immunosuppression
  3. Patients with persistent SARS-CoV-2 RNA detection +/- symptoms
- For all actions/decisions outside of the guidance above should be managed through Trust chairs actions.
- At Barts Health where 'specialist team*' is referred to, email the covid drugs panel: bartshealth.coviddrugspanel@nhs.net
  Above where it is stated 'At an increased risk of progression to severe COVID-19, this links to the following website: https://www.nice.org.uk/guidance/ta878/chapter/supporting-information-on-risk-factors-for-progression-to-severe-covid19#supporting-information-on-risk-factors-for-progression-to-severe-covid19 and see NICE TA878 for Box 2 Risk factors for progression to severe COVID-19 in young people aged 12 to 17 years

- Preparation, administration, Blueteq approval forms, etc. for each COVID-19 treatment can be found on Adult Antimicrobial Guide (microguide.global)
- Administration guidance of injectable medicines can be found on Medusa
- Use of COVID-19 medicines in pregnancy can be found by clicking here: Bumps
- Inclusion criteria forms for above COVID-19 Treatment are on Weshare, type in search the required drug: Remdesivir, Interleukin 6 inhibitor, Paxlovid, Baricitinib, etc
- Fluid Management Assessments are required for ALL inpatients with COVID-19: Fluid Management (microguide.global)provides guidance on this assessment
- Empirical antibiotic therapy is no longer recommended for suspected/confirmed COVID19 pneumonia unless there is a strong clinical suspicion of secondary bacterial pneumonia. More information can be found on COVID-19 (microguide.global)
- Drug interactions can be checked using the following resources:
  - University of Liverpool COVID-19 Drug Interactions Checker Liverpool COVID-19 Interactions (covid19-druginteractions.org)
- Where symptoms are referred to, the following are considered symptoms of COVID-19: feverish, chills, sore throat, cough, shortness of breath or difficulty breathing, nausea, vomiting, diarrhoea, headache, red or watery eyes, body aches, loss of taste or smell, fatigue, loss of appetite, confusion, dizziness, pressure or tight chest, chest pain, stomach ache, rash, sneezing, sputum or phlegm, runny nose

Appendix 2

Further information for Treatment COVID-19 NON-hospitalised patients

Table 3: Treatment of patients with NON-hospitalised adults and children aged over 12 years and older with COVID-19, who are symptomatic.

Treatment	Paxlovid (nirmatrelvir plus ritonavir) First Line	Molnupiravir Second line
Eligibility criteria for treatment	• The patient does not need supplemental oxygen for COVID-19 (may require oxygen for other conditions) **AND** • Confirmed by PCR or POCT **AND** Symptomatic with COVID-19 and not improving **AND** **The patient meets one of the following criteria:** • At an increased risk of progression to severe COVID-19, as defined in here **OR** **AND** • ≥12yrs and ≥40kg and post pubescent[4] **AND** • Treatment is commenced within 5 days of symptom onset **AND** • No history of severe renal or liver disease. These patients require their	• The patient does not need supplemental oxygen for COVID-19 (may require oxygen for other conditions) **AND** • Confirmed by PCR OR POCT **AND** • Is at an increased risk of progression to severe COVID-19, as defined in here **AND** • Treatment is commenced within 5 days of symptom onset **AND** • >18 years of age and not pregnant **AND** • Treatment with Paxlovid is contraindicated or not clinically suitable **AND**

	treatment to be discussed with the responsible specialist clinical team. **AND** • Pregnancy has been excluded in women of childbearing age. Breast-feeding should be discontinued during treatment and for 7 days after last dose **AND** • Deemed safe after assessing potential drug interactions. Please note there are numerous significant drug interactions associated with Paxlovid. **AND** • Patient does not require hospital-level care for the management of acute COVID-19 **AND** • There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients, or drug interactions **If there are significant drug interactions present between Paxlovid and the patient's current medication regimen, please consider 2nd line treatment option.**	• There are no drug contra-indications e.g., hypersensitivity to any active substances or excipients
Dose and Treatment Duration	**Paxlovid (nirmatrelvir plus ritonavir)** **Patients with eGFR >60ml/min:** 300mg (2x150mg nirmatrelvir tabs) PO with 100mg (1x100mg ritonavir tab) PO BD for 5 days. **For patients with eGFR ≥30ml/min – 60ml/min**: 150mg (1x150mg nirmatrelvir tabs) PO with 100mg (1x100mg ritonavir) PO BD for 5 days Total treatment duration: **5 days**	**Molnupiravir** PO 800mg BD Total treatment duration: 5 **days**

If the above applies patients can self-refer or clinicians can contact the CMDU service at Barts Health. Service provision transferred from Waltham Forest FedNet to Barts Health on 18 May 2026.

Email: Bartshealth.CMDUreferrals@nhs.net

CMDU team phone line: 07541 694164

Note: where it is stated ‘At an increased risk of progression to severe COVID-19, this links to the following website: https://www.nice.org.uk/guidance/ta878/chapter/supporting-information-on-risk-factors-for-progression-to-severe-covid19#supporting-information-on-risk-factors-for-progression-to-severe-covid19 and see NICE TA878 for Box 2 Risk factors for progression to severe COVID-19 in young people aged 12 to 17 years

Appendix 3: Reimbursement mechanism for COVID-19 treatments in hospitalised patients.

Acquisition of drugs

Historically, COVID-19 medicines were supplied free of charge (FOC) through DHSC central stock. Provider trusts therefore did not record these medicines through standard commissioning processes, and no charging mechanism to the ICB was required. As all DHSC COVID-19 stock has now expired or been fully utilised, these medicines have reverted to business-as-usual procurement and reporting requirements.

Summary:
- COVID-19 medicines are no longer supplied FOC.
- Provider trusts must procure these medicines through their usual commercial routes.

Provider Trust data submission to the ICB

- All usage and costs must be submitted through SLAM as part of routine high cost drug reporting.
- Trusts should not submit invoices to the ICB for COVID-19 medicines, as invoicing is not the approved mechanism for reporting this activity.

Medicines affected
The following medicines must now be included in standard SLAM activity submissions:
- Baricitinib
- Molnupiravir (Lagevrio)
- Nirmatrelvir/ritonavir (Paxlovid)
- Remdesivir
- Tocilizumab