Royal Cornwall Hospitals
NHS Trust

Treatment for Adult Inpatients with COVID-19 Clinical Guideline

V1.1

August 2025

	Available OOH
	Available if patient on ICU
	Available during pharmacy opening hours
	Available during pharmacy opening hours – seek COVID-19 MDT advice

Patient has positive COVID-19

No → Patient does not qualify for treatment.

Patient has low-flow O_2 requirement.

No → Patient is symptomatic and in "high-risk group" (outlined in Appendix 4)

Yes

Prescribe: Dexamethasone 6mg daily for 10 days (stop if patient is discharged before the course is completed)
If patient is pregnant: Prednisolone 40mg daily for 10 days.

Patient has clinical suspicion/confirmed diagnosis of COVID-19 pneumonitis e.g. on chest X-ray / CTPA

Patients receiving dexamethasone and who have rapidly increasing oxygen needs and systemic inflammation or high risk of deterioration.

Prescribe: Tocilizumab single dose as per dosing table below via IV infusion in 100mls 0.9% sodium chloride over 60 minutes via 0.2micronfilter (filter available on Grenville).

Exclusion criteria:

- Neutrophil <1x 10^9/L
- ALT/AST >5 times the upper limits of normal
- Platelets < 50x10^3/µL

Caution in patients with underlying bacterial infection – ensure adequate antimicrobial cover

Prescribe: Baricitinib (see dosing table) for 10 days (stop if patient is discharged before the course is completed)

Exclusion criteria:

- Neutrophils < 0.5x10^9/L
- Active tuberculosis
- Significant interactions with other medications

Caution in patients with underlying bacterial infection – ensure adequate antimicrobial cover

If patient belongs to high-risk group for progression to severe COVID-19:

Discuss with infections specialist MDT to consider:
Remdesivir 200mg IV OD on day 1, then 100mg IV OD for 5-10 days.
Exclusion criteria:

- ALT >5 times the upper limits of normal

Consider for patients with eGFR <30mL/min – discuss with COVID-19 specialist and Renal Physician

Prescribe: Nirmatrelvir/ritonavir (Paxlovid) (as per dosing table)

Exclusion criteria:

- Symptoms onset over 7 days before treatment initiation
- History of advanced decompensated liver cirrhosis (Child-Pugh grade C – score of 10-15)
- Presence of CKD Stage 4-5 CKD
- Significant interactions with current medications (speak with pharmacy team in hours)

Alternative:

If Paxlovid is not suitable, discuss with member of COVID-19 MDT to consider:

Remdesivir 200mg IV OD on day 1, then 100mg IV OD on day 2 and 3.

Exclusion criteria:

- ALT >5 times the upper limits of normal

Consider for patients with eGFR <30mL/min – discuss with COVID-19 specialist and Renal Physician

Dosing Guidance

Dexamethasone 6mg daily for 10 days (stop if patient is discharged before the course is completed)
If patient is pregnant: **Prednisolone** 40mg daily for 10 days.

Tocilizumab as per dosing table below via IV infusion in 100mls 0.9% sodium chloride over 60 minutes via 0.2micronfilter (available on Grenville).

Actual Body Weight (ABW)	Dose
Less than 41kg	8mg/kg, rounded to nearest 20mg
41kg – 45kg	360mg
46kg - 55kg	400mg
56kg - 65kg	480mg
66kg - 80kg	600mg
81kg - 90kg	680mg
91kg and above	800mg

Exclusion criteria:
- Neutrophil <1x 10^9/L
- ALT/AST >5 times the upper limits of normal
- Platelets < 50x10^3/µL

Caution in patients with underlying bacterial infection – ensure adequate antimicrobial.

Nirmatrelvir/ritonavir (Paxlovid)
eGFR >60mL/min: 3 tablets (Nirmatrelvir 300mg / Ritonavir 100mg) 12 hourly for 5 days
eGFR 30-60mL/min: 2 tablets (Nirmatrelvir 150mg / Ritonavir 100mg) 12 hourly for 5 days
eGFR <30mL/min: Contraindicated, unless recommended on Infection Specialist advice.

Exclusion criteria:
- Symptoms onset over 7 days before treatment initiation
- History of advanced decompensated liver cirrhosis (Child-Pugh grade C)
- Presence of CKD Stage 4-5 CKD
- Significant interactions with current medications (speak with pharmacy team in hours)

Baricitinib
eGFR ≥60mls/min - 4mg PO OD
eGFR 30 to <60mls/min - 2mg PO OD
eGFR 15 to 30mls/min - 2mg PO alternate days

Exclusion criteria:
- Neutrophils < 0.5x10^9/L
- Active tuberculosis
- Significant interactions with other medications

Caution in patients with underlying bacterial infection – ensure adequate antimicrobial.

For patients requiring oxygen therapy:
Remdesivir 200mg IV OD on day 1, then 100mg IV OD for 5-10 days.
Exclusion criteria:
- ALT >5 times the upper limits of normal

Consider for patients with eGFR <30mL/min – discuss with COVID-19 specialist and Renal Physician.

For patients deemed high risk for severe COVID-19 not requiring O_2:
Remdesivir 200mg IV OD on day 1, then 100mg IV OD for 2 days.
Exclusion criteria:
- ALT >5 times the upper limits of normal

Consider for patients with eGFR <30mL/min – discuss with COVID-19 specialist and Renal Physician.

1. Aim/Purpose of this Guideline

1.1. The purpose of this guideline is to support and advise on the therapeutical management of adults with COVID-19 in the hospital setting.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Ownership

2.1.1. Clinical responsibility of all patients receiving treatment for COVID-19 remains with the clinical team responsible for the patient at the time of treatment.

2.1.2. The COVID-19 MDT may be contacted for guidance for the management of patients with COVID-19, and consists of:

2.1.2.1. Infectious Disease Consultant.

2.1.2.2. Antimicrobial/Respiratory Specialist Pharmacists.

2.1.2.3. Respiratory Consultants.

2.1.3. Contact details available via switchboard.

2.2. COVID-19 testing

All patients with a suspected or definite diagnosis of COVID-19 should have a COVID-19 test.

2.3. Imaging

All patients with suspected COVID-19 should have a chest X-ray or chest CT requested to assess for evidence of pneumonitis.

2.4. Oxygen management

All patients who require supplementary oxygen therapy must be assessed and receive therapy that is appropriate to their clinical condition and oxygen is prescribed in-line with the Trust's guideline 'Prescription, Administration and Monitoring of Oxygen in Adults Policy'.

2.5. Venous Thromboembolism (VTE) prophylaxis

2.5.1. All patients should be assessed for the need for VTE prophylaxis in-line with the Trust's VTE policy.

2.5.2. Assess patient's risk of bleeding.

2.5.3. Check if patient is already receiving anticoagulant treatment.

2.5.4. If patient is prescribed anticoagulant treatment, continue current therapeutic dose unless contraindicated by change in clinical circumstances. If so, consider switching to LMWH as per Trust Thrombosis Prevention and Anticoagulation policy.

2.5.5. If patient is not prescribed anticoagulant treatment, then prescribe standard prophylactic LMWH dose considering weight and renal function as per Trust Thrombosis Prevention and Anticoagulation policy. Continue LMWH for a minimum of 7 days, including discharge.

2.6. Management of COVID-19 positive patients with oxygen requirement

2.6.1. Patients with a positive COVID-19 test with an oxygen requirement should be prescribed Dexamethasone 6mg daily PO (If patient cannot take orally, then Dexamethasone 3.3mg/mL injection prescribed at a dose of 6.6mg daily IV) for 10 days. If the patient is pregnant, then prescribe Prednisolone 40mg daily for 10 days instead.

2.6.2. If the patient is discharged before the 10 days of treatment, then the steroid should be stopped. Note: for patients on long-term steroids then check usual maintenance dose and revert to this at discharge if appropriate, ensuring to check if a weaning dose is required.

2.6.3. If patient's oxygen requirement increases despite treatment with dexamethasone or there is clinical suspicion/confirmed diagnosis of widespread COVID-19 pneumonitis (e.g. on chest X-ray / CTPA) then consider treatment with Tocilizumab and Baricitinib.

2.6.4. Patients should not be prescribed Tocilizumab if the patient has any of the following:

2.6.4.1. Neutrophil $<1x\ 10^9/L$.

2.6.4.2. ALT/AST >5 times the upper limits of normal.

2.6.4.3. Platelets < $50x10^3$/µL.

2.6.5. Tocilizumab may worsen co-existing infections therefore it is cautioned in patients that have active bacterial/viral infections (other than SARS-CoV2).

2.6.6. Prescribe Tocilizumab at 8mg/kg as a single dose based on the patient's actual bodyweight dose banded up to a maximum of 800mg, as per dosing table shown in Appendix 3.

2.6.7. For patients with sudden deterioration and increasing oxygen requirements, then Tocilizumab is available on ICU for use within ICU setting only. All other supplies must be supplied during pharmacy opening hours.

2.6.8. Baricitinib may be prescribed alone alongside corticosteroid therapy if treatment with Tocilizumab is contraindicated/unsuitable or as add on therapy when there is clinical deterioration despite treatment with Tocilizumab.

2.6.9. Patients should not be prescribed Baricitinib if the patient has any of the following:

2.6.9.1. Neutrophils < $0.5x10^9$/L

2.6.9.2. Active tuberculosis

2.6.9.3. Significant interactions with other medications

2.6.9.4. eGFR < 15mL/min

2.6.10. Baricitinib may worsen co-existing infections therefore it is cautioned in patients that have active bacterial/viral infections (other than SARS-CoV2).

2.6.11. Prescribe Baricitinib based on the patient's renal function as below:

2.6.11.1. eGFR ≥60mls/min - 4mg PO OD

2.6.11.2. eGFR 30 to <60mls/min - 2mg PO OD

2.6.11.3. eGFR 15 to 30mls/min - 2mg PO alternate days

2.6.11.4. eGFR <15mls/min – Contraindicated

2.6.12. For patients with swallowing difficulties then the tablets may be chewed or can be dispersed in 10mL of water for administration.

2.6.13. For administration via nasogastric and gastrostomy tubes, the tablets can be dispersed in 15-30mL of water. Take care to avoid clogging the tip of the enteral syringe during administration.

2.6.14. For patients who are requiring supplemental oxygen and are at an increased risk for progression of severe COVID-19, as defined in Appendix 4, then Remdesivir is recommended as an option for add-on therapy.

2.6.15. Consult with a member of the COVID-19 MDT during pharmacy opening hours to discuss appropriateness for treatment with Remdesivir. Remdesivir is not stocked within the hospital and will only be dispensed during pharmacy opening hours.

2.6.16. Patients should not be prescribed Remdesivir if the patient has any of the following:

- ALT > 5 times the upper limit.
- Patients with severe renal impairment (eGFR < 30mL/min) and those on Haemodialysis may be prescribed Remdesivir; this should be discussed with a COVID-19 MDT member and a Renal Physician.
- If appropriate, then prescribe Remdesivir at a dose of 200mg IV daily on day 1 then 100mg IV daily from days 2 to 5. Review treatment at day 5; treatment may be extended up to 10 days if patient is immunocompromised.

2.7. Management of COVID-19 positive patients without oxygen requirement:

2.7.1. Do not use corticosteroids to treat COVID-19 in people who do not need supplemental oxygen. (People who need corticosteroids for another medical reason should still have them.)

2.7.2. All adults with a positive COVID-19 test and symptomatic with COVID-19 but not requiring oxygen therapy should be prescribed Nirmatrelvir plus ritonavir (Paxlovid) if they have:

An increased risk for progression of severe COVID-19 as defined in Appendix 4.

2.7.3. Patients should not be prescribed Nirmatrelvir plus ritonavir (Paxlovid) if the patient has any of the following:

2.7.3.1. Symptoms onset over seven days before treatment initiation.

2.7.3.2. History of advanced decompensated liver cirrhosis (Child-Pugh grade C – score 10-15).

2.7.3.3. Presence of Chronic Kidney Disease (CKD) stage 4 or 5.

2.7.3.4. Significant interactions with concurrent medications which cannot be managed safely (speak with pharmacy team during opening hours).

2.7.4. Prescribe Nirmatrelvir plus ritonavir 150mg/100mg (Paxlovid) tablets based on the patient's renal function as below:

2.7.4.1. eGFR >60mL/min: Three tablets (two pink 150mg tablets and one white 100mg tablet) 12 hourly PO for 5 days.

2.7.4.2. eGFR 30-60mL/min: Two tablets (one pink 150mg tablet and one white 100mg tablet) 12 hourly PO for 5 days.

2.7.4.3. eGFR <30mL/min: Contraindicated, unless recommended on Infection Specialist advice.

2.7.5. For patients that cannot receive Nirmatrelvir plus ritonavir 150mg/100mg (Paxlovid) then the patient can be considered for treatment with Remdesivir.

2.7.6. Remdesivir is recommended as an option for adults (weighing at least 40 kg) who do not require supplemental oxygen and who are at an increased risk for progression of severe COVID-19, as defined in Appendix 4, where Paxlovid is contraindicated or unsuitable.

2.7.7. Consult with member of COVID-19 MDT during pharmacy opening hours to discuss appropriateness for treatment with Remdesivir. Remdesivir is not stocked within the hospital and will only be dispensed during pharmacy opening hours.

2.7.8. Patients should not be prescribed Remdesivir if the patient has any of the following:

ALT > 5 times the upper limit

2.7.9. Patients with severe renal impairment (eGFR < 30mL/min) and those on Haemodialysis may be prescribed Remdesivir; this should be discussed with a COVID-19 MDT member and a Renal Physician.

2.7.10. If appropriate, then prescribe Remdesivir at a dose of 200mg daily IV on day 1, then 100mg daily IV on day two and three.

2.7.11. Sotrovimab is not recommended locally due to the lack of convincing data to support its use, as outlined in the WHO Therapeutic and COVID-19 Living Guideline (published 10th Nov 2023).This is contrary to the recommendation in the NICE guidance which states that Sotrovimab is an option for patients not requiring supplemental oxygen and at an increased risk for progression of severe COVID-19, as defined in Appendix 4, where Paxlovid is contraindicated or unsuitable.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	The number of patients prescribed Tocilizumab, Baricitinib, Paxlovid and Remdesivir.
Lead	Daniel Hearsey and the COVID-19 MDT.
Tool	Monitored as part of antimicrobial stewardship activity in the hospital and patient criteria compared to the NICE clinical guidelines NG191 COVID-19 rapid guideline: managing COVID-19.
Frequency	On-going monitoring, reported two monthly.
Reporting arrangements	Antimicrobial Stewardship Management Committee (ASMC). Medicines Practice Committee (MPC).
Acting on recommendations and Lead(s)	The ASMC will lead on subsequent recommendations made by the MPC.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a month. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Treatment for Adult Inpatients with COVID-19 Clinical Guideline V1.1
This document replaces (exact title of previous version):	Treatment for Adult Inpatients with COVID-19 Clinical Guideline V1.0
Date Issued/Approved:	12 August 2025
Date Valid From:	August 2025
Date Valid To:	April 2028
Directorate / Department responsible (author/owner):	Daniel Hearsey – Antimicrobial Pharmacist
Contact details:	01872 253548
Brief summary of contents:	Guidance on the therapeutical management of adults with COVID-19 in the hospital setting.
Suggested Keywords:	COVID-19, antivirals, dexamethasone, tocilizumab, baricitinib, Paxlovid, remdesivir.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Medicine Practice Committee
Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming consultation and ratification:	Kevin Wright
Links to key external standards:	NICE Guideline NG.
Related Documents:	None required
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pharmacy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
13/11/2024	V1.0	Initial issue	Daniel Hearsey (Antimicrobial Pharmacist)
12/08/2025	V1.1	Update to cohort eligible for Paxlovid in patients not requiring oxygen	Daniel Hearsey (Antimicrobial Pharmacist)

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	COVID-19 Treatment Guideline V1.1
Directorate and service area:	Pharmacy Department
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Daniel Hearsey, Antimicrobial Pharmacist
Contact details:	01872 253548

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Doctors, nurses and pharmacists.
2. Policy Objectives	To manage COVID-19 in-line with NICE clinical guidelines.
3. Policy Intended Outcomes	Correct and safe prescribing of COVID-19 therapeutics.
4. How will you measure each outcome?	Audit.
5. Who is intended to benefit from the policy?	Patients, healthcare systems, wider society.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: No • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Infectious Disease Consultant, Respiratory Consultants, Microbiology Consultants, Medicines Practice Committee (MPC).
6c. What was the outcome of the consultation?	Agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** Staff.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Daniel Hearsey, Antimicrobial Pharmacist.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Dosing Table for Tocilizumab for Treatment of COVID-19

(Reference: NHS Tayside 'Tocilizumab Guidance in Adult COVID-19 Patients' available at Tocilizumab Guidance.pdf)

Actual Body Weight (ABW)	Dose
Less than 41kg	8mg/kg, rounded to nearest 20mg
41kg – 45kg	360mg
46kg - 55kg	400mg
56kg - 65kg	480mg
66kg - 80kg	600mg
81kg - 90kg	680mg
91kg and above	800mg

Appendix 4. Risk factors for progression to severe COVID-19 in adults

Defined by the independent advisory group commissioned by the Department of Health and Social Care (June 2023).

Category	Information
Down's syndrome and other genetic disorders	• All individuals with Down's syndrome or other chromosomal disorders known to affect immune competence.
Solid cancer	• Metastatic or locally advanced inoperable cancer. • Lung cancer (at any stage). • People receiving any chemotherapy (including antibody-drug conjugates), PI3K inhibitors or radiotherapy within 12 months. • People who have had cancer resected within 3 months and who received no adjuvant chemotherapy or radiotherapy. • People who have had cancer resected within 3 to 12 months and receiving no adjuvant chemotherapy or radiotherapy are expected to be at less risk (and thus less priority) but still at increased risk compared with the non-cancer populations.
Haematological diseases and recipients of haematological stem cell transplant (HSCT)	• Allogeneic HSCT recipients in the last 12 months or active graft versus host disease (GVHD) regardless of time from transplant (including HSCT for non-malignant diseases). • Autologous HSCT recipients in the last 12 months (including HSCT for non-malignant diseases). • Individuals with haematological malignancies who have received CAR-T cell therapy in the last 24 months, or until the lymphocyte count is within the normal range. • Individuals with haematological malignancies receiving systemic anti-cancer treatment (SACT) within the last 12 months, or radiotherapy in the last 12 months. All people who do not fit the criteria above, and are diagnosed with: • Myeloma (excluding monoclonal gammopathy of undetermined significance [MGUS]). • AL amyloidosis. • chronic B-cell lymphoproliferative disorders (chronic lymphocytic leukaemia, follicular lymphoma). • myelodysplastic syndrome (MDS). • chronic myelomonocytic leukaemia (CMML). • Myelofibrosis.

Category	Information
	• Any mature T-cell malignancy. • All people with sickle cell disease. • People with thalassaemia or rare inherited anaemia with any of the following: • Severe cardiac iron overload (T2 * less than 10 ms). • Severe to moderate iron overload (T2 * greater than or equal to 10 ms) plus an additional comorbidity of concern (for example, diabetes, chronic liver disease or severe hepatic iron load on MRI). • Individuals with non-malignant haematological disorders (for example, aplastic anaemia or paroxysmal nocturnal haemoglobinuria) receiving B-cell depleting systemic treatment (for example, anti-CD20, anti-thymocyte globulin [ATG] and alemtuzumab) within the last 12 months.
Renal disease	Renal transplant recipients (including those with failed transplants within the past 12 months), particularly those who have: • received B-cell depleting therapy within the past 12 months (including alemtuzumab, rituximab [anti-CD20], ATG.) • an additional substantial risk factor that would in isolation make them eligible for monoclonals or oral antivirals. • Non-transplant renal patients who have received a comparable level of immunosuppression. • People with chronic kidney disease (CKD) stage 4 or 5 (an estimated glomerular filtration rate [eGFR] less than 30 ml per min per 1.73 m2) without immunosuppression.
Liver diseases	• People with cirrhosis Child-Pugh (CP) class A, B and C, whether receiving immune suppressive therapy or not. Those with decompensated liver disease (CP B and C) are at greatest risk. • People with a liver transplant. • People with liver disease on immune suppressive therapy (including people with and without cirrhosis).
Solid organ transplant recipients	• Solid organ transplant recipients not in any of the above categories.
Immune-mediated inflammatory disorders (diseases in which autoimmune or autoinflammati	• People who have received a B-cell depleting therapy (anti-CD20 drug, for example, rituximab, ocrelizumab, ofatumumab, obinutuzumab) in the last 12 months. • People who have been treated with cyclophosphamide (IV or oral) in the 6 months prior to positive PCR or relevant COVID test.

Category	Information
on-based pathways are implicated in disease, for example, inflammatory arthritis, connective tissue diseases, inflammatory skin diseases, inflammatory gastrointestinal disease)	• People who are on corticosteroids (equivalent to 10 mg or more per day of prednisolone) for at least the 28 days prior to positive PCR or relevant COVID test. • People who are on biologics or small molecule JAK inhibitors. • People who are on current treatment with mycophenolate mofetil, oral tacrolimus, azathioprine, mercaptopurine, or similar agents (for major organ involvement such as kidney, gastro-intestinal tract, liver, lung, brain), methotrexate (for interstitial lung disease or asthma only) and/or ciclosporin. No minimum dose threshold is suggested. • People who are on current treatment (or within the last 6 months) with S1P modulators (fingolimod, ponesimod or siponimod), or alemtuzumab or cladribine within the last 12 months. • People who exhibit at least one of: (a) uncontrolled or clinically active disease (that is, required recent increase in dose or initiation of new immunosuppressive drug or IM steroid injection or course of oral steroids within the 3 months prior to positive PCR or relevant COVID test); and/or (b) other high risk comorbidities (for example, body mass index [BMI] greater than 30, diabetes mellitus, hypertension, major organ involvement such as significant kidney, liver, nervous system or lung inflammation or significantly impaired renal, liver, nervous system and/or lung function).
Respiratory	• Asthma in people on oral corticosteroids (defined above). Any asthma patient taking immunosuppressants for their asthma including but not exclusively methotrexate, ciclosporin. Frequent exacerbations requiring 4 or more courses of prednisolone per year, usually 40 mg per day for 5 days or more. • COPD on long term home non-invasive ventilation (NIV). Patients on long term oxygen therapy. People with moderate or severe disease (FEV1 less than or equal to 50% predicted) who have required 4 or more courses of prednisolone 30 mg for 5 days or greater in last 12 months. • Interstitial lung disease (ILD) – all patients with idiopathic pulmonary fibrosis. • Sub-types of ILD, for example, connective tissue disease related, sarcoidosis, hypersensitivity pneumonitis, NSIP (non-specific interstitial pneumonia) who have received a B-cell depleting therapy in last 12 months, or IV or oral cyclophosphamide in the 6 months prior to testing positive for COVID-19. Any ILD patient on current treatment with corticosteroids, mycophenolate mofetil, azathioprine, tacrolimus, cyclosporin or methotrexate. No minimum dose criteria.

Category	Information
	• Any people with any type of ILD who may not be on treatment due to intolerance but has severe disease with an FVC predicted less than 60%. • NIV and tracheostomy ventilated – all patients requiring this type of support regardless of the underlying disorder (which might include COPD, obesity hypoventilation syndrome, scoliosis, bronchiectasis, neurodisability and genetic muscular diseases [refer to neurology section]). • Lung cancer patients, refer to 'Solid cancer' section above. • Lung transplant patients (refer to solid organ transplant section). • Pulmonary hypertension (PH): groups 1 and 4 from PH classification.
Immune deficiencies	• Common variable immunodeficiency (CVID). • Undefined primary antibody deficiency on immunoglobulin (or eligible for Ig.) • Hyper-IgM syndromes. • Good's syndrome (thymoma plus B-cell deficiency). • Severe combined immunodeficiency (SCID). • Autoimmune polyglandular syndromes or autoimmune polyendocrinopathy, candidiasis, ectodermal dystrophy (APECED syndrome). • Primary immunodeficiency associated with impaired type 1 interferon signalling. • X-linked agammaglobulinaemia (and other primary agammaglobulinaemias). • Any person with secondary immunodeficiency receiving, or eligible for, immunoglobulin replacement therapy.
HIV/AIDS	• People with high levels of immune suppression, have uncontrolled or untreated HIV (high viral load) or present acutely with an AIDS defining diagnosis. • People on treatment for HIV with CD4 less than 350 cells per mm3 and stable on HIV treatment or CD4 greater than 350 cells per mm3 and additional risk factors (for example, age, diabetes, obesity, cardiovascular, liver or renal disease, homeless, alcoholic dependency).
Neurological disorders	Conditions associated with neuromuscular respiratory failure requiring chronic ventilatory support: • Motor neurone disease. • Duchenne muscular dystrophy. Conditions that require use of specific immunotherapies:

Category	Information
	• Multiple sclerosis (MS). • Myasthenia gravis (MG). • Other immune-mediated disorders. Dementia, neurodegenerative and neuroimmune disorders when associated with severe frailty (for example, levels 7 or 8 on Clinical Frailty Scale, as part of a personalised care plan): • Alzheimer's disease, vascular disease, Lewy body disease, or frontotemporal atrophy. • Parkinson's disease. • Huntington's disease. • Progressive supranuclear palsy and multiple system atrophy. • Motor neurone disease. • Multiple sclerosis and other immune-mediated neurological disorders.