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| FOR IMMEDIATE RELEASE | CONTACT |
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## ISMP Issues Recommendations to Prevent Paxlovid Errors

### *Numerous Dosing Mistakes Have Been Reported to ISMP, FDA*

**Plymouth Meeting, Pa.**– In the last few months, the Institute for Safe Medication Practices (ISMP) and the U.S. Food and Drug Administration (FDA) have received dozens of reports of wrong dose errors related to PAXLOVID (nirmatrelvir and ritonavir), which is indicated for the treatment of mild-to-moderate COVID-19. ISMP is alerting healthcare professionals, especially pharmacists, who have an important role to play in error prevention.

The cover article in the June 30, 2022, issue of the *ISMP Medication Safety Alert!® Acute Care* newsletter outlines the causes and contributing factors of reported errors and provides safe practice recommendations. Paxlovid currently is available in tablet form in two blister pack configurations, with different dosing and a specific blister pack for patients who have moderate renal impairment.

Several of the reported errors involved improper renal dosing, such as prescribing or dispensing Paxlovid to patients with severe renal impairment. There also have been many errors during self-administration, including patients taking the wrong number of tablets or taking tablets at the wrong time.

“ISMP is emphasizing the need to educate patients using the teach back method, since blister pack instructions can be quite confusing,” says ISMP President Rita K. Jew, PharmD, MBA, BCPPS, FASHP. “Providing patients with the Paxlovid *Fact Sheet for Patients, Parents, and Caregivers (*[*https://www.fda.gov/media/155051/download*](https://www.fda.gov/media/155051/download)*)* is a requirement and provides printed instructions to follow; if patients have questions they should contact their pharmacist.”

ISMP safe practice recommendations for Paxlovid include:

* **Increase awareness.** Educate prescribers and pharmacists about the reduced-dose blister package for patients with moderate renal impairment and who should receive it.
* **Check EHR configuration.** Ensure it is intuitive to select 2 of the 150 mg nirmatrelvir tablets to make up a 300 mg dose. On drop down menus, it is safest to list Paxlovid as a 300 mg and 100 mg dose pack, or a 150 mg and 100 mg dose pack (as stated on cartons).
* **Provide clinical decision support.** If possible, give guidance for Paxlovid in prescribing systems, such as an order sentence with dosing for patients with moderate renal impairment.
* **Check and confirm renal function.** There is a screening checklist tool available from the FDA that can also help identify significant drug interactions: <https://www.fda.gov/media/158165/download>
* **Avoid communicating the dose by tablet or blister color.** Referring to color can cause the patient to misunderstand which to take.
* **Educate patients.** Show patients how the medication is labeled on the blister pack, and make sure they know which tablets to take and when, and to remove each tablet just prior to taking the dose.

For a copy of the ISMP newsletter article with more details and the full list of recommendations, visit: <https://www.ismp.org/resources/numerous-wrong-dose-errors-paxlovid>

**About the Institute for Safe Medication Practices**

The Institute for Safe Medication Practices (ISMP) is the nation’s first 501c (3) nonprofit organization devoted entirely to preventing medication errors. ISMP is known and respected for its medication safety information. For more than 25 years, it also has served as a vital force for progress. ISMP’s advocacy work alone has resulted in numerous necessary changes in clinical practice, public policy, and drug labeling and packaging. Among its many initiatives, ISMP runs the only national voluntary practitioner medication error reporting program, publishes newsletters with real-time error information read and trusted throughout the global healthcare community, and offers a wide range of unique educational programs, tools, and guidelines. In 2020, ISMP formally affiliated with ECRI to create one of the largest healthcare quality and safety entities in the world, and ECRI and the ISMP PSO is a federally certified patient safety organization by the U.S. Department of Health and Human Services. As an independent watchdog organization, ISMP receives no advertising revenue and depends entirely on charitable donations, educational grants, newsletter subscriptions, and volunteer efforts to pursue its life-saving work. Visit [www.ismp.org](about:blank) and follow @ismp\_org to learn more.