Navigating OSC Through COVID!

Living with COVID

Facing Challenging Times

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GP Shared Care Obstetric

connect care innovate

Acknowledgement of Country

I would like to acknowledge the traditional owners of the lands from where each of us is joining this webinar today.

I wish to pay my respects to their Elders past, present and emerging.

GP Obstetric Shared Care Team

GP Partners Australia | Program Staff:

- **Leanne March**

GP Obstetric Shared Care Program Manager and Midwife

- **Naomi Pointon**

GP Obstetric Shared Care Program Support Officer

GP Partners Australia | GP Advisor:

- **Dr Jenni Goold**

GP Obstetric Shared Care

Impact of Coronavirus (COVID-19)

GP Obstetric Shared Care – Learning Outcomes

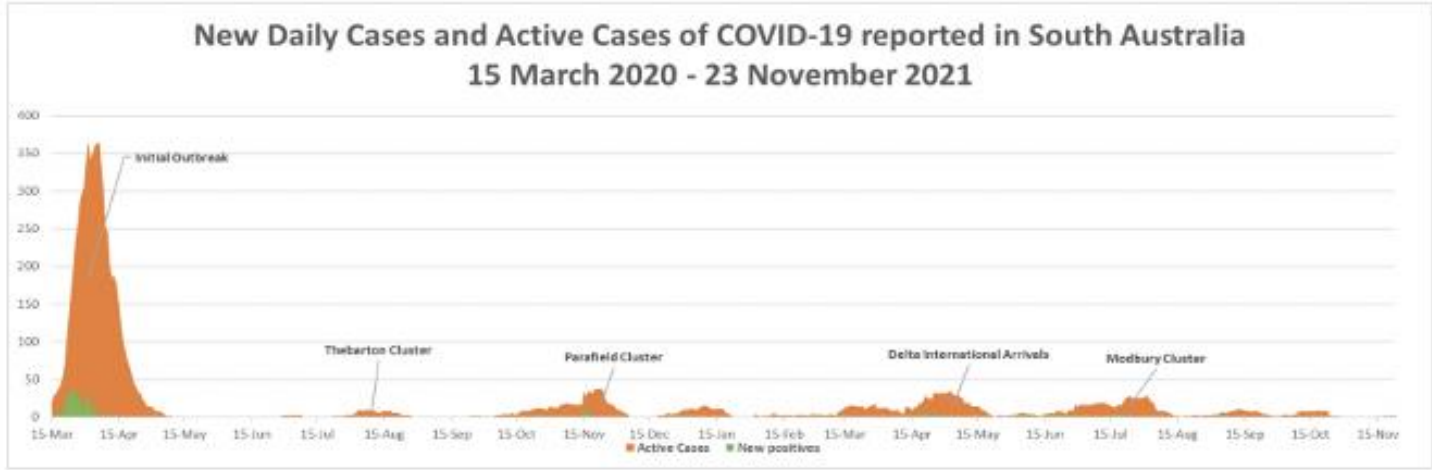
- Overview of current COVID-19 in SA

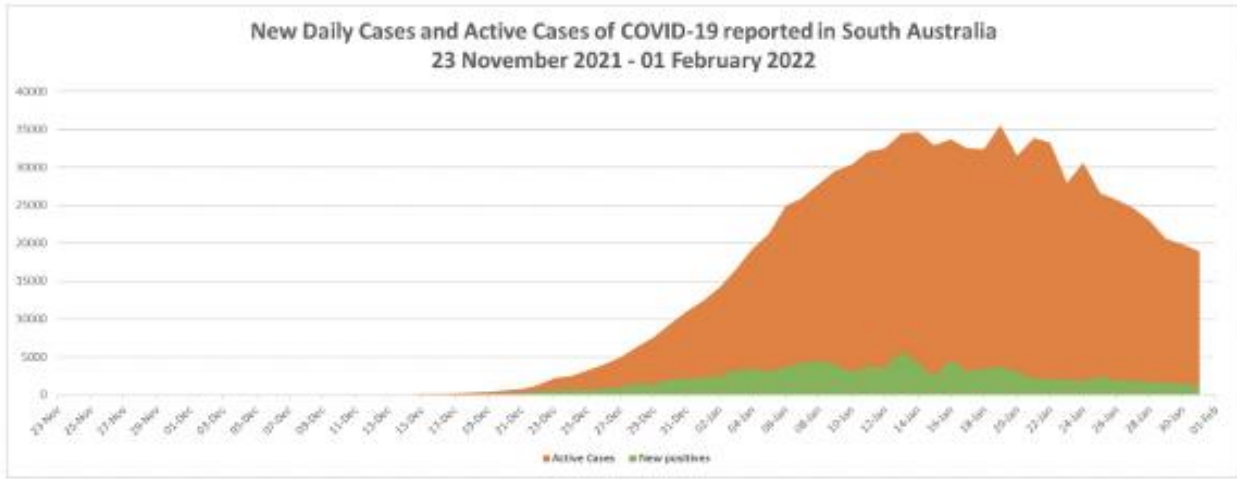
- Impact on SA GP OSC Program

- Manage a low-risk pregnancy (OSC pregnancy) at all stage of gestation in COVID environment:
  - COVID positive
  - sCOVID
  - nonCovid

- Identify and manage key risk factors encountered in COVID community spread in low-risk pregnancies

- Looking forward – living with COVID





RACGP
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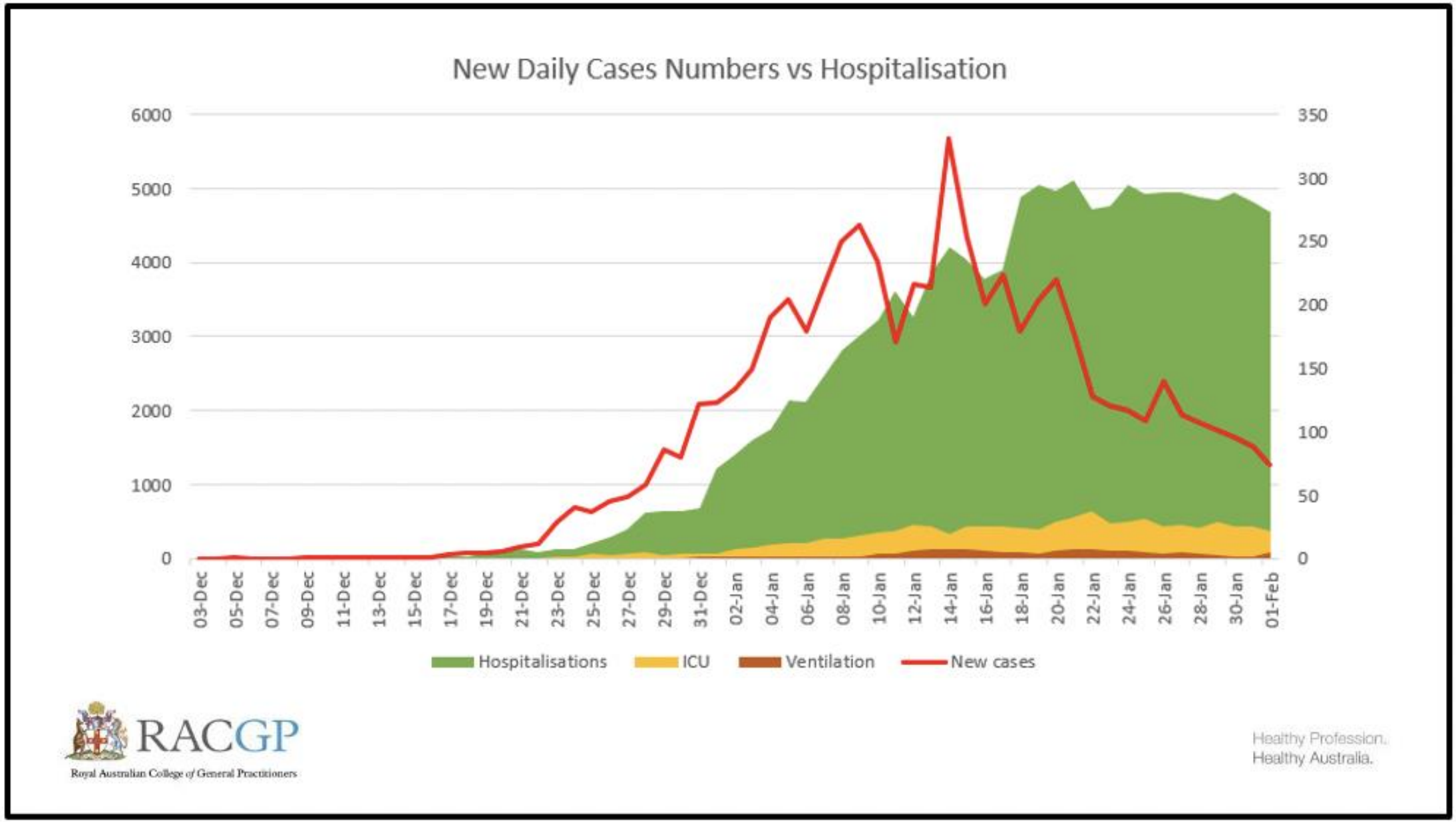
Healthy Profession.
Healthy Australia.



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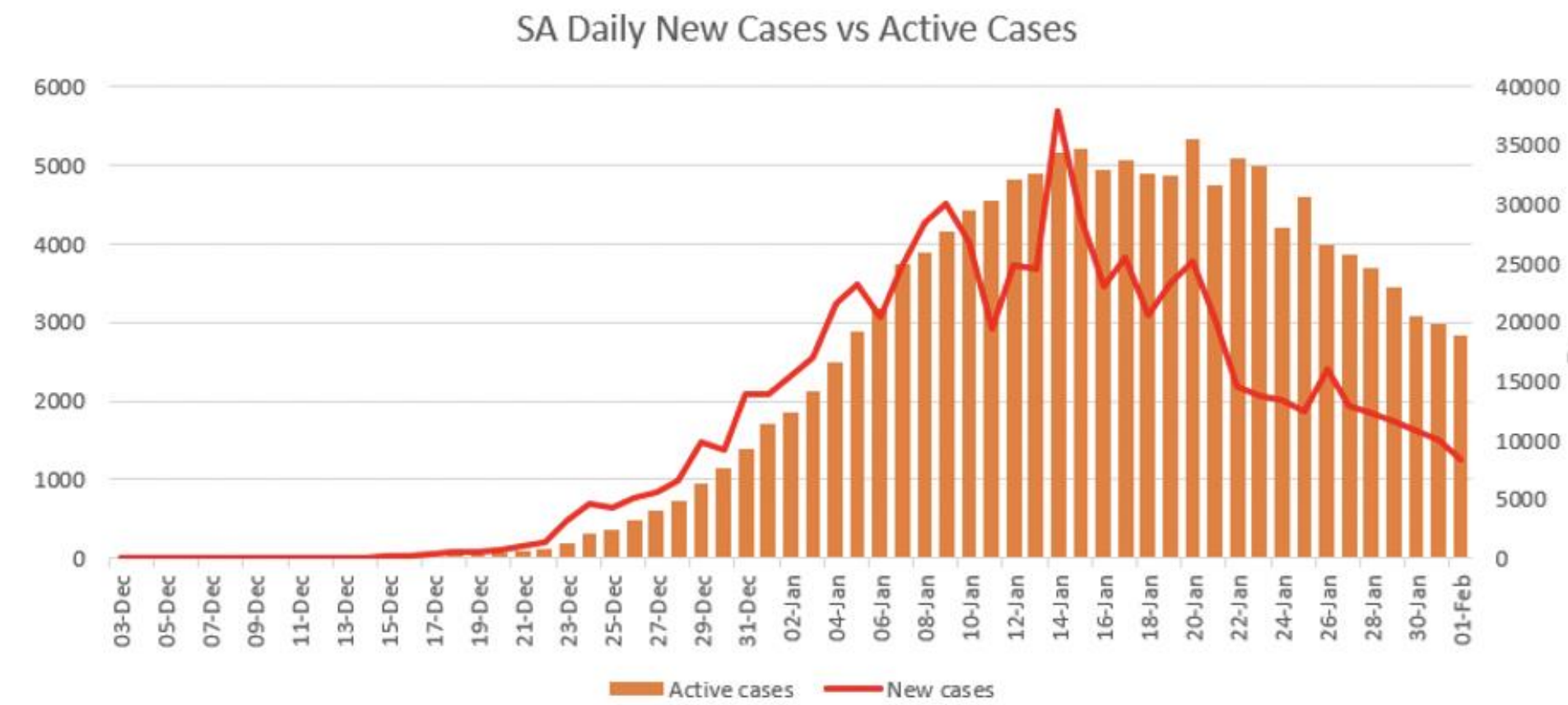

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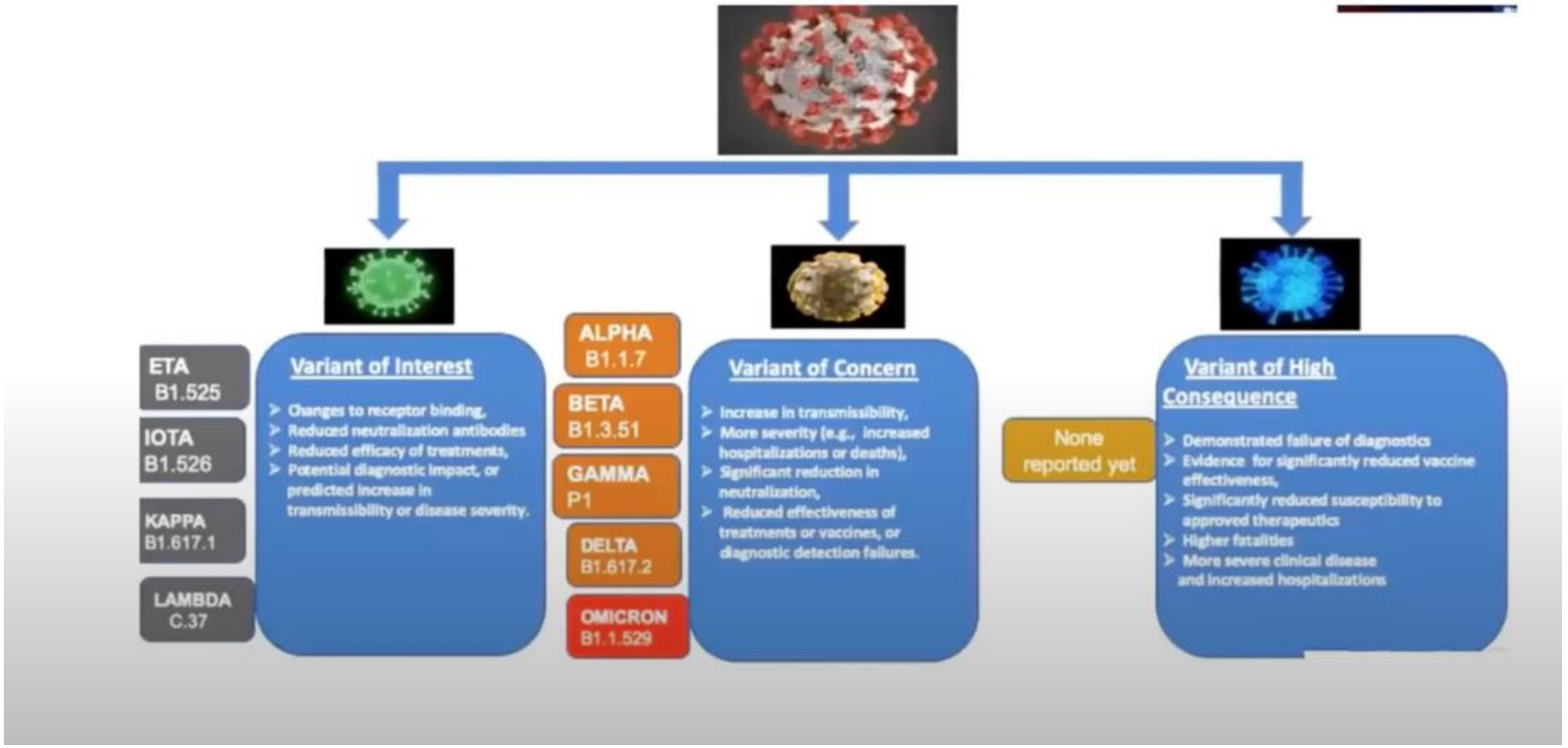
COVID-19


ETA
B1.525
IOTA
B1.526
KAPPA
B1.617.1
LAMBDA
C.37
Variant of Interest
Changes to receptor binding,
Reduced neutralization antibodies
Reduced efficacy of treatments,
Potential diagnostic impact, or predicted increase in transmissibility or disease severity.
ALPHA
B1.1.7
BETA
B1.3.51
GAMMA
P1
DELTA
B1.617.2
OMICRON
B1.1.529
Variant of Concern
Increase in transmissibility,
More severity (e.g., increased hospitalizations or deaths),
Significant reduction in neutralization,
Reduced effectiveness of treatments or vaccines, or diagnostic detection failures.
None reported yet
Variant of High Consequence
Demonstrated failure of diagnostics
Evidence for significantly reduced vaccine effectiveness,
Significantly reduced susceptibility to approved therapeutics
Higher fatalities
More severe clinical disease and increased hospitalizations

OMICRON

Not more infective but more immuno-evasive, so greater spread
Hence why efficacy of vax decreased and importance of booster
Variant identification by Genome sequencing of all hospitalised patients
only 1 delta in recent times - all omicron or subvariant

SA Health's COVID-19 Omicron health response

Prediction from evidence and experience

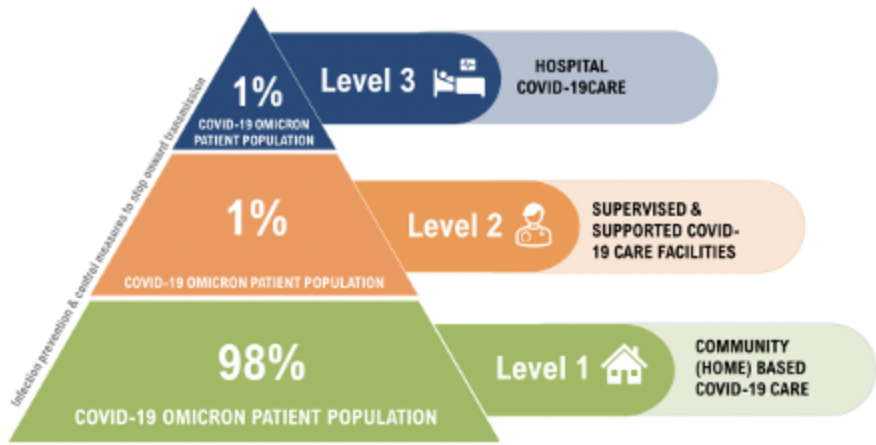
- 98% of COVID-19 Omicron cases can be safely managed through home-based care

Under Delta planning, SA Health anticipated approximately 300 COVID-19 positive cases in hospital.

In adapting to Omicron, SA Health planned to manage up to 500 cases in hospital.

Updated Omicron modelling predicted peak cases to be between 6,000 and 10,000 per day assuming current public health measures remained in place

NOTE: Modelling continues to be updated in real time based on real data.



Role of GP in supporting SA Health system response

Health system response pathway

HealthPathways SOUTH AUSTRALIA

healthdirect

- continue to support patients with non-COVID-19 health needs (either in person or via telehealth where the opportunity arises to minimise the need for patients to always attend appointments in person)
- continue to offer preventative healthcare and vaccinations (including COVID-19 vaccination)
- perform COVID-19 tests in their clinic, if it is safe and appropriate to do so, including taking a swab test outside while the patient remains in their car, or they may send patient to a drive-through testing clinic
- support patients who are COVID-19 asymptomatic or have mild disease and symptoms (low and medium risk) of COVID-19
- escalate patients who deteriorate to moderate and severe disease (high / very high risk) ensuring those involved are aware of patient's status as COVID-19 positive and their risk factors for deterioration
- liaise with SA Health GP Assessment Team (GPAT) and COVID Response Care Team (CRCT) for a patient's COVID-19 care and existing co-morbidities including in acute and post-acute illness (for IV infusion referrals).

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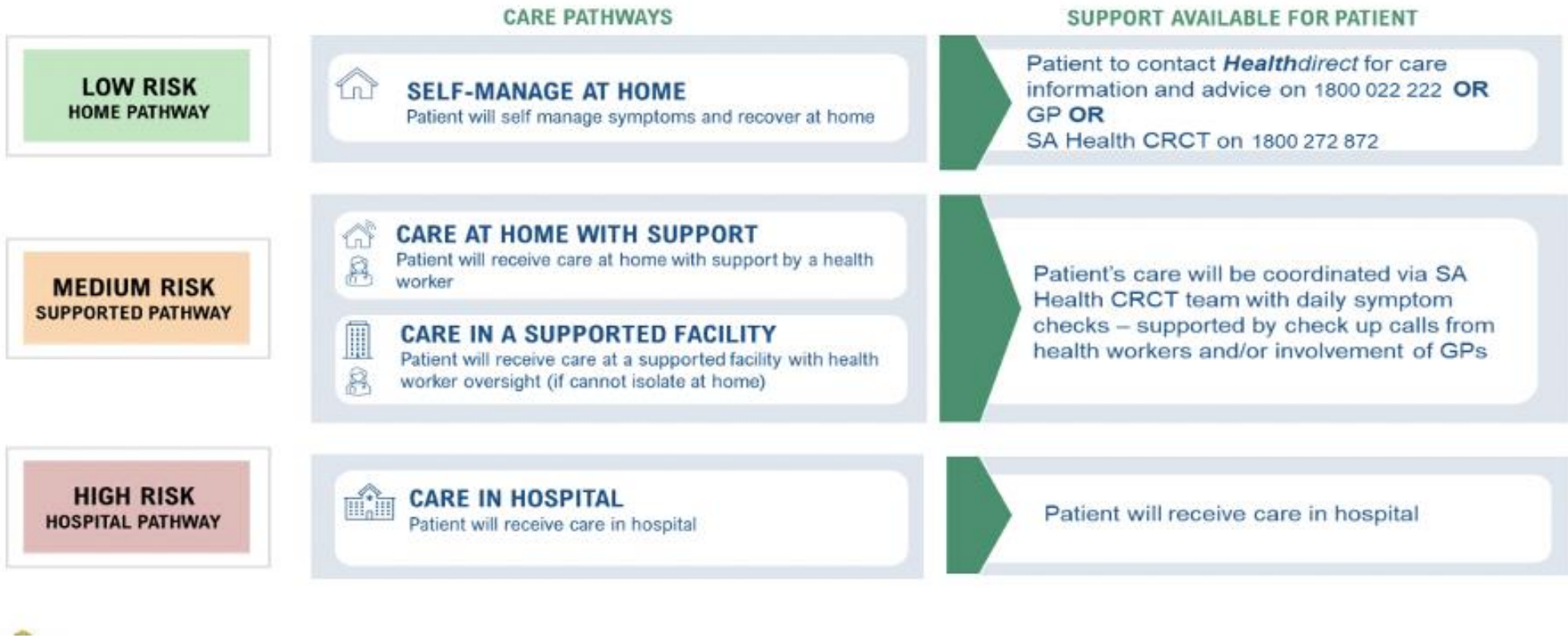
SA Health has developed pathways to facilitate direct referral from community-based clinicians for monoclonal antibody infusions for immunocompromised and unvaccinated, at-risk patients who develop COVID-19. Work is underway to expand the pathway based on recently approved oral therapies, expected to be available in the first quarter of 2022.

Healthy Profession. Healthy Australia.

Care pathways for adults who test positive for COVID-19



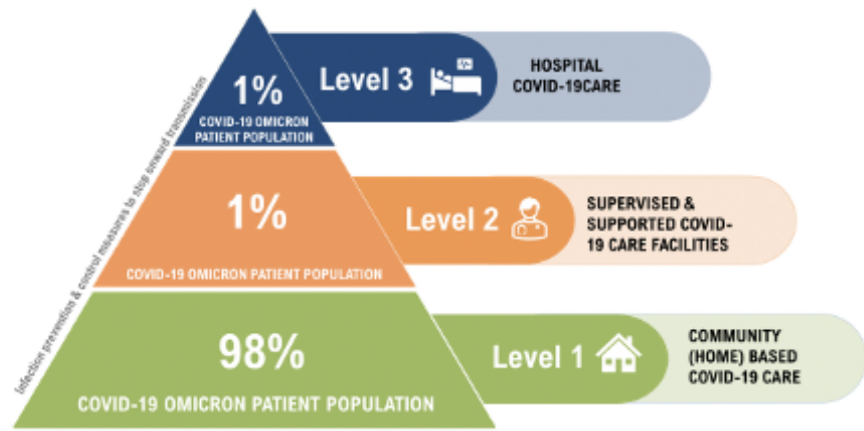
State-wide community COVID-19 Omicron Patient Care Model

LOW RISK – HOME PATHWAY

COMMUNITY (HOME) BASED COVID-19 CARE

Patient advised on **SELF MANAGEMENT** at home and to contact:

- **Health*direct* for care information, advice & escalatiuon**
- **USUAL GP** for **medical care (COVID & non-COVID)**
- **CRCT 1800 272 872 for logistics and support services**

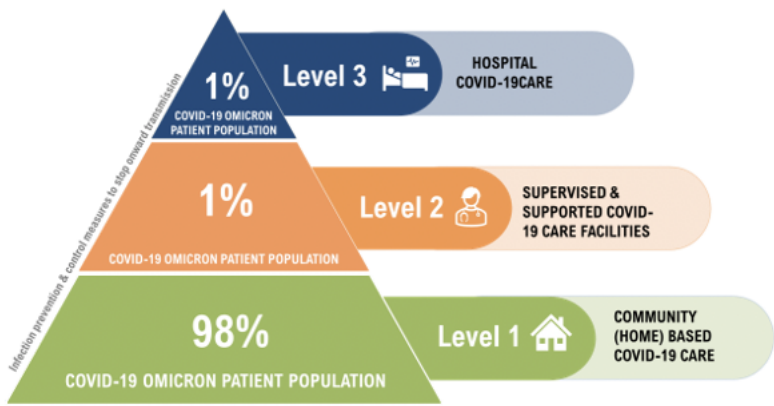


State-wide community COVID-19 Omicron Patient Care Model

MEDIUM RISK – SUPPORTED PATHWAY

CLINICAL MONITORING & CARE AT HOME OR SUPPORTED COVID-19 CARE FACILITY

- CRCT / GPAT monitoring and care
- COVID Hospital in the Hotel
- Supervised Regional Care Facilities

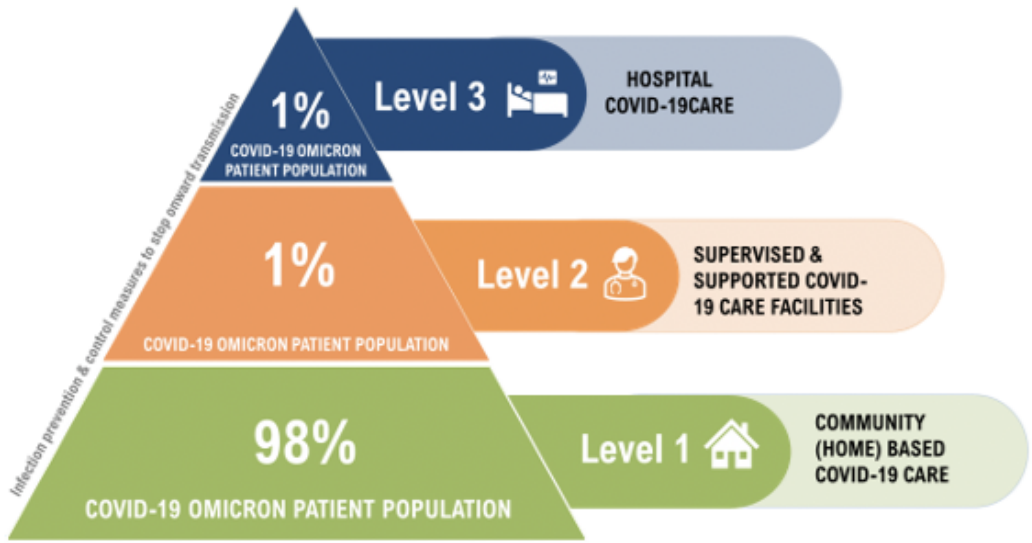


State-wide community COVID-19 Omicron Patient Care Model

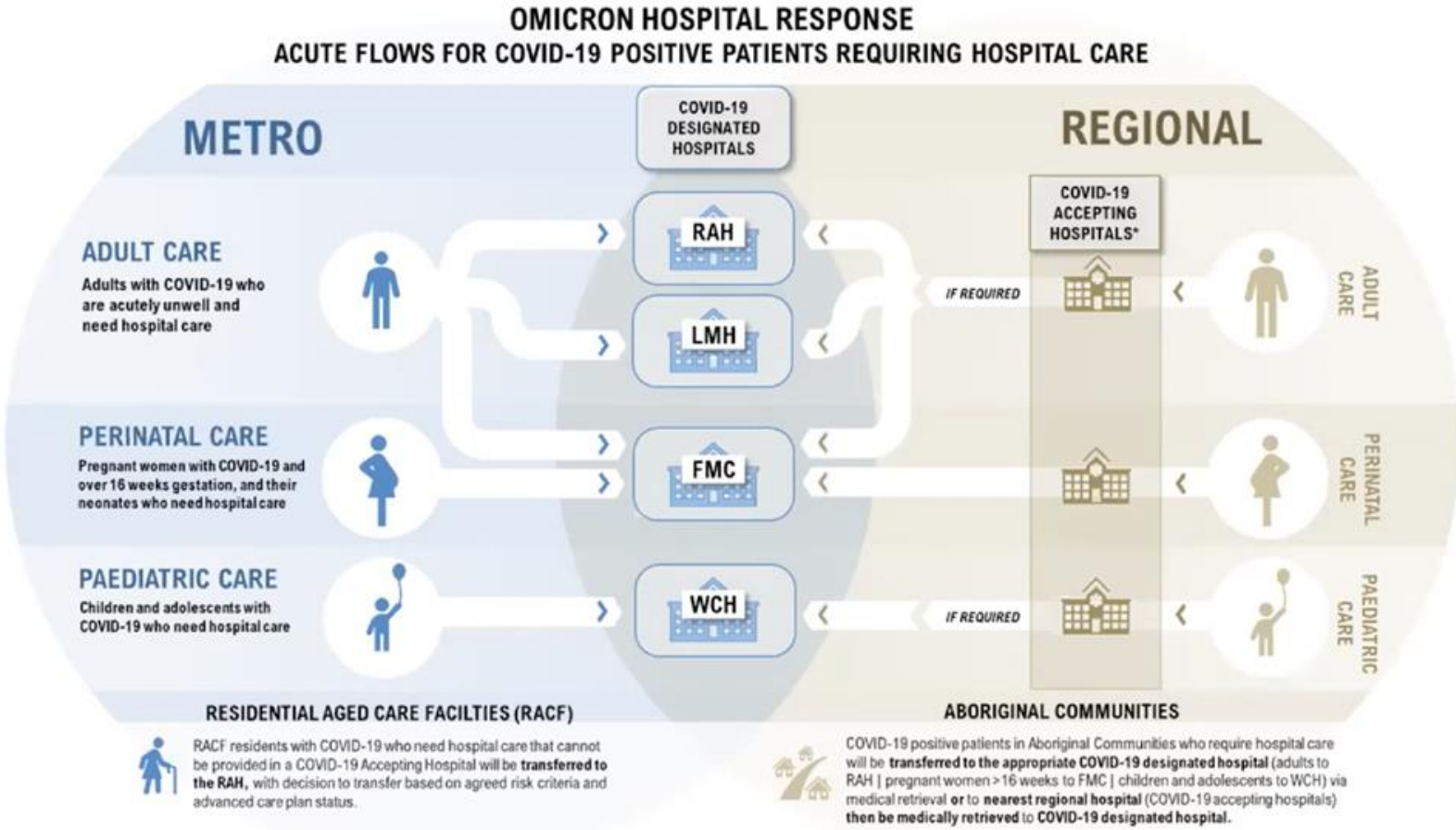
HIGH RISK – HOSPITAL PATHWAY

ACUTE AND HOSPITAL COVID-19 CARE

- COVID Care Centre
- Intensive Care Unit
- Hospital Admission
- Emergency Department



High risk – hospital pathway



PATIENTS WHO ARE SUSPECTED COVID-19 POSITIVE AND ACUTELY UNWELL REQUIRING HOSPITAL CARE MAY BE MEDICALLY TRANSFERRED/RETRIEVED DIRECTLY TO COVID-19 DESIGNATED HOSPITALS

* An acute facility that can safely care for a COVID-19 positive patient with respiratory intervention, without compromising the ability to deliver non-COVID-19 health care. The COVID-19 accepting hospital needs to be able to stabilise patients and escalate retrieval protocols to ensure that tertiary care can be accessed, as required.

Resources for GPs

Telehealth
Video calls
Covid Care kits/ Remote monitoring devices
Virtual Care service
Health direct
Pathways- pregnancy SALHN, Children- WCH & COVIDkids, Adults RAH , Mental health RAH, CRCT, GP Assessment Team, Medihotels, COVID Care Centre's, ED, local facilities for isolation- Ceduna, Port Augusta, Park 23, Edan hills

COVID-19 & GP Obstetric Shared Care

- GPs essential in Covid space & especially in pregnancy care
- Vaccinate, encourage following of restriction, Covid testing if CC/ symptoms, Mental health,usual healthcare needs & pregnancy care

Perfect time to keep women out of tertiary centres & in GP rooms-

how to do this safely?- PPE, <15min F2F, min companions

- Protocols- impact of COVID
- Booking visits; phone and phone consults available
- Guidelines- management of COVID-19 in pregnancy in SA
- COVID-19 vaccination in pregnancy, post partum
- Additional treatments/ at risk groups- MAB? Oral antivirals? VTE?
- f/u post clearance, baby care, vax schedule
- Mental health
- Support for GPs to care for pregnant/post partum + women in community & their babies

Management of COVID-19 in Pregnancy in South Australia

Management of
COVID-19 in Pregnancy
in South Australia

v7.2 03/02/2022

GP Obstetric Shared Care- Hospital Bookings Routine Process
(not covid +)

Metro:

LMHS- OSC F2F in community clinic (MW - Siobhan Lucas)

WCH- phone triage visit (MW - Sarah Clark)

-other visits can be F2F or women can opt for phone

FMC- OSC F2F (MW - Lisa Walker)

(Covid +)

notify birthing/ booking hospital for addition to covid clinic (weekly phone call)

T/H for support over COVID illness

GP Obstetric Shared Care - OSC Suggested Visit Schedule

business as usual

	GESTATION	LOCATION
1st visit	Diagnosis	GP
2nd visit	10-12 weeks	GP or Hospital
3rd visit	22 weeks	GP (if the woman has been seen at the participating hospital, otherwise visit at participating hospital)
4th visit	28 weeks	GP
5th visit	32 weeks	GP
6th visit	34 weeks	GP
7th visit	36 weeks	Hospital
8th visit	38 weeks	GP
9th visit	40 weeks	Hospital

GP Obstetric Shared Care

Document in SAPR – Current Version 13

- Gestation (completed weeks)
- Progress
- BP - seated, correct cuff, Right arm
- Fundal height in cm and plot on graph
- Fetal heart rate
- Fetal movements
- Investigation results
- Presentation and descent from 30 weeks

GP Obstetric Shared Care

How to continue F2F care and risk mitigate

- **GP and staff Fully Vax**
- **N95, google/face shield**
- **Limit F2F to under 15 minutes- phone & F2F for examination? Wait in car & SMS**
- **Limit those accompanying**

sCOVID/ COVID + use telehealth

- **If need support- usual mechanism/ if require F2F- options**

Exposure in practice- CC- matrix SA Health

GP Obstetric Shared Care

Routine Antenatal Booking Tests & investigations: BAU

- **booking**

CBP, Blood group and antibody screen, Rubella titre, Omega 3, Syphilis, Hepatitis B, Hepatitis C, HIV, Ferritin, MSSU for MCS,

<25 years Chlamydia screening – urine PCR, Vit D if at risk

- **MSS (bloods >9wks & < 14 weeks/ scan 12wks / NIPT >9wk)**
- **Early GTT 12-16weeks**
- **Morph scan**
- **28 weeks bloods**- CBP, VIT D, Ab (Rh -),syphilis if high risk, Ferritin & GTT
- ANTI-D if required 28 & 34 weeks
- **LVS-** GBS 36 weeks and CBP/Ferritin if abnormal at 28 weeks
- **Specialised tests/follow up;** Growth scans/ AFI/ Dopplers/ BA/ PE monitoring/ Anti D following sensitising event

COVID-19 & GP Obstetric Shared Care

COVID + women – birth at FMC

If present to LHN maybe birthed there (discuss with FMC)

Specialised care- WCH for MFM & cardiac babies

Where to go for assistance? For all +

F2F

>16 weeks any issue F2F assessment via FMC obs/ BAS

<16 weeks if pregnancy related, via FMC or if nonpregnant related at RAH ED or CCC (via CRCT)

Advice only

LHN where booked/zoned

GP Obstetric Shared Care

Recommended immunisations during pregnancy:

- **COVID-19 Pfizer mRNA (Cominarty) vaccine:**
  - **recommended at any stage in pregnancy (RANZCOG)**
  - This is because the risk of severe outcomes from COVID-19 is significantly higher for pregnant women and their unborn baby
  - Pregnant women are encouraged to discuss with their GP
  - Women who are trying to become pregnant do not need to delay vaccination or avoid becoming pregnant after vaccination.

GP Obstetric Shared Care- COVID-19 vax

- Safe to Vax in pregnancy and BF; dose 1, 2 & booster (if second dose >3 months)
- Use Pfizer / moderna (Novavax- insufficient safety data)

If don't vax;

> 5 x higher risk of req hospital

> 2-3 x higher risk of ICU

> 1.5 x preterm baby or needing nursery care

- Vax schedule if become covid + then schedule vax dose (1 & 2) when feeling well
- Booster post infection- delay booster 3 months (ATAGI)

GP Obstetric Shared Care

Recommended immunisations during pregnancy:
Schedule with >1 week from COVID vax

- **Influenza vaccine:**
  - Recommended at any stage in pregnancy
  - Government subsidised

- **Pertussis vaccine:**
  - Only available in polyvalent form (dTpa)
  - From 20 weeks – Vaccinate by 32 weeks
  - Government subsidised (Adacel)

GP Obstetric Shared Care GP Role

- Vaccinate
- Usual pregnancy care
- Follow up of pregnancy issues
- Supportive care for COVID illness (viral illness)- fever, myalgia hydration, hyperemesis exacerbation….
- Identify those with risk factor placing them at greater risk of disease progression & monitor/ refer
- LOOK OUT FOR RED FLAGS- obstetric & COVID!
- Specific considerations in pregnancy;

  Monoclonal Antibody (MAB) Infusion-sotrovamab

  (not oral antivirals)

  VenousThrombo Embolism (VTE) prophylaxis

Sheet 9. PREGNANT C0VID-19 positive treatment flowchart (including MAB)

For emergency maternity care patients can call: 8204 5511 and ask for the Birthing and Assessment Suite (BAS) or 000

If a COVID-19 positive pregnant woman needs to attend hospital to birth or receive care, they will be cared for at FMC if:

- greater than 16 weeks gestation
- less than 16 weeks gestation and have pregnancy-related complications

SECOND OR THIRD TRIMESTER PREGNANT YES

MILD DISEASE YES

Patient is unvaccinated or partially vaccinated (See Box 3 on previous page for definition of partially vaccinated)
YES

Patient is immunosuppressed (See Slide 8 for what is and is not included)
YES

Clinical concerns requiring F2F or escalation (as per Triaging Flow Chart on Slide 2)
OR
Advanced pregnancy with any worsening symptoms
YES

Risk factors for progressing to severe or critical illness (see Box 2 previous page)
NO

Risk factors for progressing to severe or critical illness (see Box 2 previous page)
Yes

Not for MAB

>7 days since symptom onset

Not for MAB

≤7 days since symptom onset

Complete online form Link on GPAT portal under 'Important information' if patient meets OR is likely to meet criteria.
No need to call the relevant CCC if it is Day 6 or 7

INFUSION MORE LIKELY TO BE GIVEN AT FMC CCC IF URGENT (REGIONAL CCC ALSO AVAILABLE)
No need to call ID consultant unless there is a clinical issue requiring advice.

>7 days since symptom onset

Not for MAB

REMEMBER TO ASSESS ALL COVID-19 POSITIVE PREGNANT WOMEN FOR VTE PROPHYLAXIS AS PER CRIB SHEET 10

Contact FMC O&G COVID Reg on DECT phone (8204 7898) to discuss escalations and, if required, directly handover care

Current infusion recommendations:

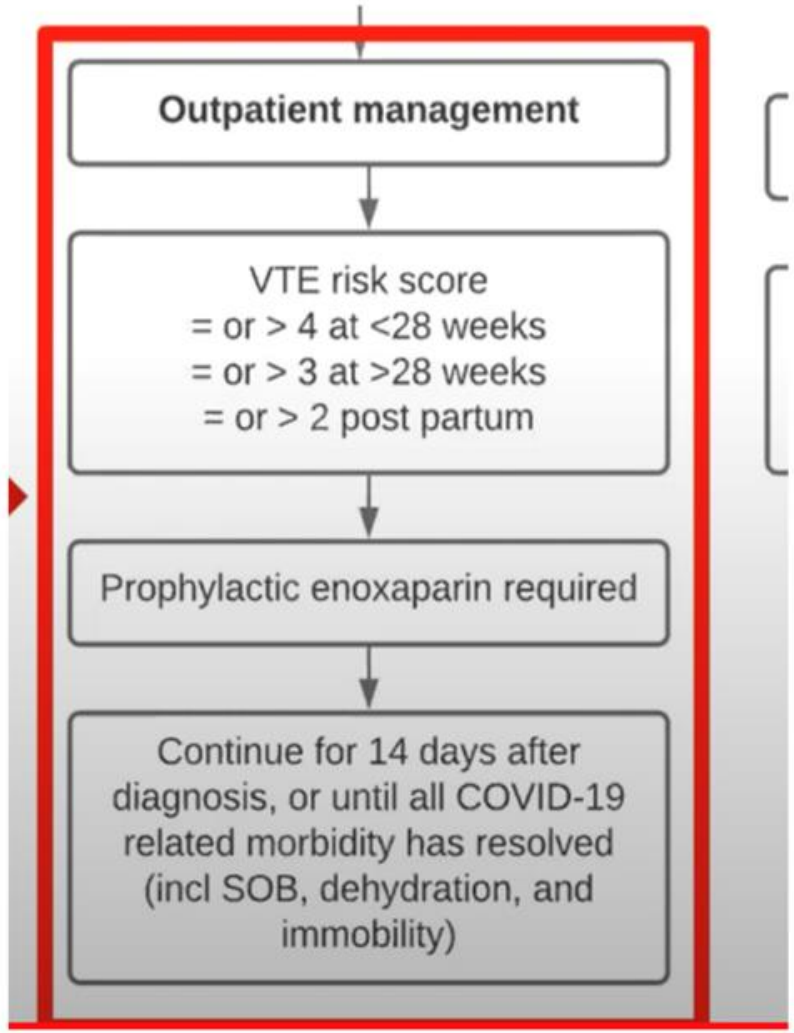
NO INFUSIONS ARE GIVEN DURING FIRST TRIMESTER PREGNANCY

VTE Risk Assessment & Prophylaxis in pregnancy

Active COVID-19-risk of VTE & pregnancy elevates baseline risk

An assessment tool is used to obtain a score, & if eligible, discuss with birthing hospital & commence Enoxaparin as per dosage guidelines.

HITH/ MRU can administer in home



post hospital discharge, further 14 days or until all COVID morbidity resolved

VTE Risk scoring

Outpatient management Threshold for treatment	
< 28 weeks	Score ≥ 4
≥ 28 weeks	Score ≥ 3
Post-partum - Active COVID-19 within the first 6 weeks after birth - Women who have had COVID-19 in pregnancy but are negative at the time of birth	Score ≥ 2

Pre-existing risk factors	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory polyarthropathy or inflammatory bowel disease; nephrotic syndrome; type I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1[a]
Age (> 35 years)		1
Obesity		1 or 2[b]
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric risk factors		
Pre-eclampsia in current pregnancy		1
ART/IVF (antenatal only)		1
Multiple pregnancy		1
Caesarean section in labour		2
Elective caesarean section		1
Mid-cavity or rotational operative delivery		1
Prolonged labour (> 24 hours)		1
PPH (> 1 litre or transfusion)		1
Preterm birth < 37[+0] weeks in current pregnancy		1
Stillbirth in current pregnancy		1
Transient risk factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendicectomy, postpartum sterilisation		3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
TOTAL		

Abbreviations: ART assisted reproductive technology; IVF in vitro fertilisation; OHSS ovarian hyperstimulation syndrome; VTE venous thromboembolism.

[a] If the known low-risk thrombophilia is in a woman with a family history of VTE in a first-degree relative postpartum thromboprophylaxis should be continued for 6 weeks.

[b] BMI ≥ 30 = 1; BMI ≥ 40 = 2

1 point should be added if the patient is dehydrated or immobile

Dosing of Enoxaparin

Prophylaxis	Dosing
Creatinine Clearance (CrCl) <30mL/min or body weight < 50kg	Enoxaparin 20mg daily or Unfractionated Heparin 5000 units BD*
Weight 50-90kg + CrCl >30mL/min	Enoxaparin 40mg subcut daily
Weight 91-130kg + CrCl >30mL/min	Enoxaparin 60mg subcut daily
Weight 131-170kg + CrCl >30mL/min	Enoxaparin 80mg subcut daily
Weight >170kg + CrCl >30mL/min	Consult Obstetrics Medicine or Haematology

Cautions and contraindications for VTE Prophylaxis

Imminent delivery
Known bleeding disorder (e.g. haemophilia, von Willebrand's disease or acquired coagulopathy)
Active antenatal or post-partum bleeding
Increased risk of major haemorrhage (e.g. placenta praevia)
Thrombocytopenia (Plt <75 x 10^9/L)
Acute stroke in previous 4 weeks (haemorrhagic or ischaemic)
Severe renal disease (GFR <30ml/minute/1.73m^2)
Severe liver disease (prothrombin time above normal range or known varices)
Uncontrolled hypertension (blood pressure >200mmHg systolic or >120 mmHg diastolic)

Administration of enoxaparin

We currently do not have a single-entry pathway for arranging administration, so please try the following:

1. If the patient has a private Obstetrics provider, try to contact this person for a handover OR
2. If a patient is booked at a public hospital for Obsterics, call the O&G Reg at that hospital to discuss and provide a verbal handover OR
3. Call the O&G COVID Registrar at Flinders Medical Centre on 8204 7898 to discuss and provide a verbal handover

Box 3: Definition of partially vaccinated:

Only 1 vaccination *(same as before)*
<2 weeks since second vaccination *(same as before)*
>4 months since second AstraZeneca vaccine (NEW)
>5 months since second Moderna or Pfizer vaccine (NEW)
<7 days since booster vaccine (NEW)

Box 2: Risk factors for progressing to severe or critical COVID-19 illness

- Age ≥ 55 years or ≥ 35 for Aboriginal and Torres Strait Islander
- Diabetes or gestational diabetes AND requiring medication
- Obesity BMI > 30kg/m^2 and < 45kg/m^2 PLUS additional risk factor
- Obesity BMI > 45kg/m^2
- Kidney disease (eGFR < 30 mL/min OR for pregnant women eGFR < 60 mL/min)
- Chronic Kidney Disease (eGFR 30-60 mL/min)
- Chronic liver disease (cirrhosis)
- Congenital heart disease
- Congestive heart failure (NHYA Class II or above)
- Cardiovascular disease PLUS additional risk factor
- Moderate to severe asthma (on inhaled corticosteroid or prescribed course of oral steroid in previous 12 months)
- Chronic lung disease (chronic bronchitis, COPD, emphysema with dyspnoea on exertion)
- Sickle Cell Disease
- Pregnancy: See dedicated page for this

Box 1: Immunosuppressed Classification (See Slide 8 for what is and is not included)

Primary or acquired immunodeficiency

- Haematological neoplasm (leukemias, lymphomas or myelodysplastic syndromes)
- Post-transplant: solid organ transplant on immunosuppressive therapy, haematopoietic stem cell transplant within 24 months
- Immunocompromised due to primary or acquired (HIV/AIDS) immunodeficiency

Other significantly immunocompromising conditions

- Current or recent immunosuppressive therapy
- Chemotherapy or radiotherapy
- High dose corticosteroids (≥ 20mg prednisolone per day or equivalent) for ≥ 14 days
- Biological therapy or disease-modifying anti-rheumatic drugs (DMARDs)

MAB Infusion - Risk factors

Vaccination status	Risk factors for progressing to severe illness	Immunocompromising conditions
• No vaccination • Received 1 vaccine • < 2 weeks since second vaccine • > 4 months since second vaccine AZ • >5 months since second vaccine Pfizer • < 7 days since booster • Fully vaccinated but immunocompromised	• Age > 55 years or > 35 for Aboriginal and Torres Strait Islander • Diabetes or pregestational diabetes AND requiring medication • Chronic kidney disease (eGFR < 60 mL/min) • Chronic liver disease (cirrhosis) • Obesity (BMI > 30kg/m2 and <45kg/m2 + additional risk factor) • Obesity BMI > 45kg • Moderate to severe asthma (on inhaled corticosteroid or prescribed course of oral steroid in previous 12 months) • Chronic lung disease (chronic bronchitis, COPD, emphysema with dyspnoea on exertion) • Congestive heart failure (NHYA Class II or above) • Cardiovascular disease	• Haematological neoplasm (leukaemia, lymphoma or myelodysplastic syndrome) • Haematopoietic stem cell transplant within 24 months • Solid organ transplant on immunosuppressive therapy • Primary or acquired (HIV/AIDS) immunodeficiency • Current or recent immunosuppressive therapy • Chemotherapy or radiotherapy • High dose corticosteroids (≥ 20mg prednisolone per day or equivalent) for ≥ 14 days • Biological therapy or disease-modifying anti-rheumatic drugs

Sheet 8. Immunocompromised and MABs-included and excluded conditions and therapies

24-7 MEDCARE

PLEASE NOTE: asplenic or hyposplenic patients are not classified as immunosuppressed

The following patient groups are eligible for monoclonal antibody therapy for the treatment of COVID-19 disease

- Active haematological malignancy
- Non-haematological malignancy with current active treatment (e.g., chemotherapy, whole body irradiation)
- Solid organ transplant with immunosuppressive therapy
- Haematopoietic stem cell transplant (HSCT) recipients or chimeric antigen receptor T-cell (CAR-T) therapy within 2 years of transplantation
- Primary immunodeficiency including combined immunodeficiency and syndromes, major antibody deficiency (e.g. common variable immune deficiency (CVID) or agammaglobulinemia), defects of innate immunity (including phagocytic cells), defects of immune regulation, complement deficiencies and phenocopies of primary immunodeficiencies.
- Advanced or untreated HIV with CD4 counts < 250/µL or those with a higher CD4 count unable to be established on effective antiretroviral therapy.
- Patients prescribed immunosuppressive therapies including:
    - High dose corticosteroid treatment equivalent to > 20mg/day of prednisone for ≥ 14 days in a month, or pulse corticosteroid therapy.
    - Multiple immunosuppressants where the cumulative effect is severely immunosuppressive (for examples refer to 'excluded therapies' below.
    - Selected conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDS):
        - **including** mycophenolate, methotrexate (≥ 10 mg/week), leflunomide, azathioprine (≥ 1mg/kg day), 6-mercaptopurine (≥ 0.5mg/kg/day), alkylating agents (e.g. cyclophosphamide, chlorambucil), and systemic calcineurin inhibitors (e.g. cyclosporin, tacrolimus).
        - **excluding** hydroxychloroquine when used as monotherapy.
    - Biologic and targeted therapies anticipated to reduce the immune response to COVID-19 vaccine. Refer to table below for examples. However, clinicians may use their judgement for medications which are not listed.

Included biologic and targeted therapies

Class	Examples
Anti-CD20 antibodies	rituximab, obinutuzumab, ocrelizumab, ofatumumab
BTK inhibitors	ibrutinib, acalabrutinib, zanubrutinib
JAK inhibitors	tofacitinib, baricitinib, ruxolitinib, upadacitinib
Sphingosine 1-phosphate receptor modulators	fingolimod, siponimod
Anti-CD52 antibodies	alemtuzumab
Anti-complement antibodies	eculizumab
Anti-thymocyte globulin (ATG)	anti-thymocyte globulin (e.g. ATGAM®, Thymoglobuline®, ATG-Grafalon®)
Pyrimidine and purine synthesis inhibitors	teriflunamide, cladribine
Other agents	abatacept, belimumab, blinatumomab, dimethyl fumarate, tocilizumab

Excluded therapies

The following therapies, when **not** given in combination with other immunosuppressive therapies, are likely to have a minimal effect on COVID-19 vaccine response. Patients prescribed these therapies are **not** eligible for monoclonal antibody therapy for treatment of COVID-19 illness:

- Anti-TNF-α antibodies (e.g. infliximab, adalimumab, etanercept, golimumab, certolizumab)
- Anti-IL1 antibodies (e.g. anakinra), Anti-IL4 antibodies (e.g. dupilumab), Anti-IL6 antibodies (e.g. siltuximab)
- Anti-IL17 antibodies (e.g. apremilast, secukinumab, ixekizumab)
- Anti-IL23 antibodies (e.g. guselkumab, risankizumab, tildrakizumab, ustekinumab)
- Immune checkpoint inhibitors (e.g. atezolizumab, durvalamab, ipilimumab, nivolumab, pembrolizumab)
- Integrin receptor inhibitors (e.g. natazilumab, vedolizumab)
- Interferons, Glatiramer
- VEGF, EGFR and HER2 blockers (e.g. cetuximab, panitumumab, pertuzumab, traztuzumab, bevacizumab)

MAB Referral
www.sahealth.sa.gov.au/covidinfusion

Box 3: Definition of partially vaccinated:

MAB INFUSION APPLICATION FOR COVID-19 POSITVE PATIENTS (INCLUDING PREGNANT)

Consider early in disease to reduce likelihood of disease progression

Eligibility;

COVID + confirmed by PCR (not Rapid Antigen Test (RAT)),mild symptoms

Less than 7 days since onset of symptoms or + test (which ever earlier)

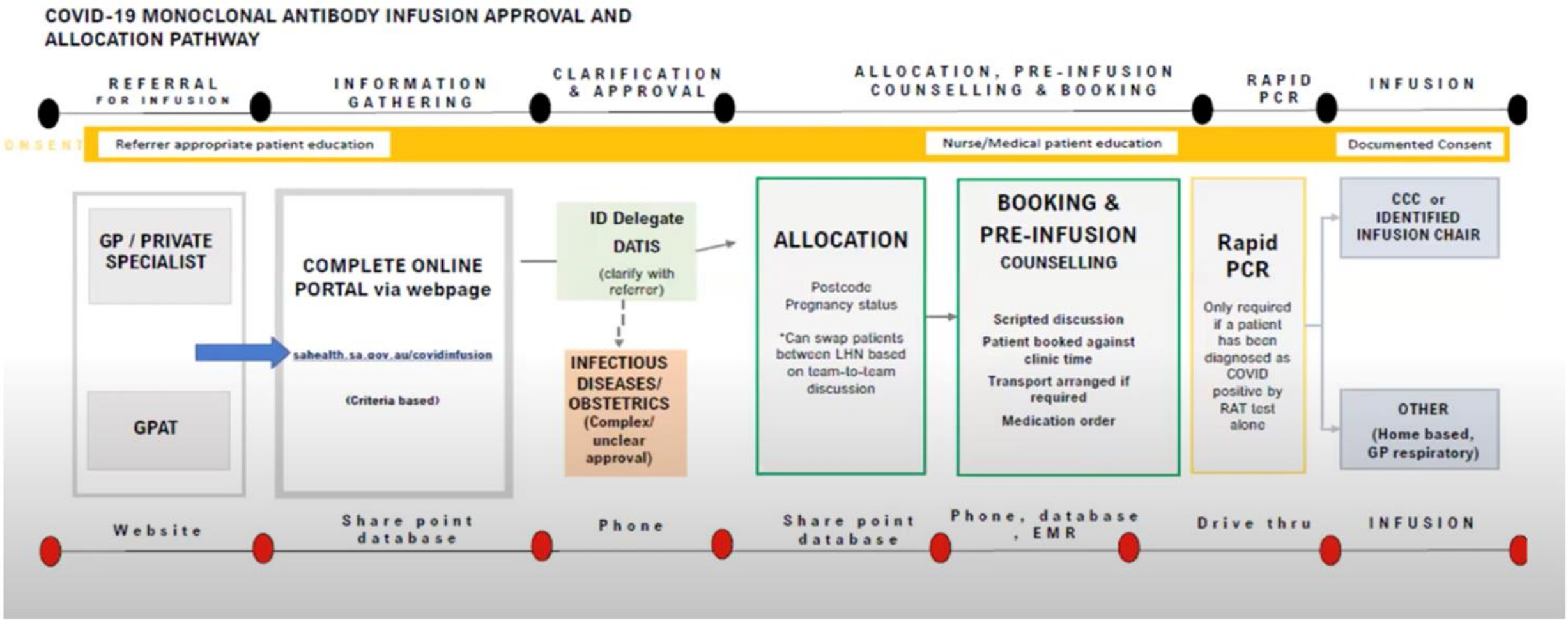
Not requiring oxygen therapy

Immunosuppressed (as outlined in the application form)

Or

Unvax or partially vax & have risk factor for disease deterioration

COVID-19 MONOCLONAL ANTIBODY INFUSION APPROVAL & ADMINISTRATION PATHWAY



MAB Infusion – Current locations

METROPOLITAN ADELAIDE

LHN Location	Pre-infusion Counselling	Referral Process	Contact Details
FMC		WWW.sahealth.sa.gov.au/covidinfusion.com.au	
RAH		WWW.sahealth.sa.gov.au/covidinfusion.com.au	
LMH	Clinic Currently in set up phase	WWW.sahealth.sa.gov.au/covidinfusion.com.au	

REGIONAL SOUTH AUSTRALIA

Location Local Health Network	Pre-infusion Counselling - SA VTS default	Referral Processes agreed	Contact Details
*Eyre Far North (EFN)	SA VTS	No	Dr Susan Merrett - *processes required*
Riverland Murray Coorong (RMC) **Berri and Murray Bridge**	Yes	Yes	Dr Caroline Phegan
*Yorke & Northern (YN)	SA VTS	No	Dr Viney Joshi – *processes required*
*Barossa Hills Fleurieu (BHF)	SA VTS	No	Dr Sharon Morton – *Case by Case only for Kangaroo Island maybe considered*
*Flinders Upper North (FUN)	SA VTS	No	*Dr Nes Lian-Lloyd - Staffing and processes required*
Limestone Coast (LC) **Mount Gambier**	Yes	Yes	Dr Elaine Pretorius
			*** All Subject to change**

RACGP
Royal Australian College of General Practitioners

GP Obstetric Shared Care

ORAL ANTIVIRALS- <5 days (similar criteria MAB)

Paxlovid- (combination Nirmatrelvir & ritanovir
Drug interactions, altered dose with renal function, not preg or BF

Molnupiravir- not in preg, avoid BF 4 days (Males contraception for 3 mo) 30% efficacy

Large tablets/ capsules- cant crush or open
No tailing off effect like Sotrovamab
Not for pregnancy or BF

COMMON QUESTIONS

CLEARANCE

CDCB has simplified the process as of 2 January 2022.

All COVID-19 positive patients will be automatically cleared 10 days post test collection, irrespective of vaccination status or symptoms. This will be via an automated message sent directly to patients on Day 9.

This should be the message given to all patients who ask questions regarding clearance.

Return to work?
do I need to test before I have my baby?
Who can support me in my birthing experience?
Who can visit me?
Postnatal care?- for mothers encourage BF infant suggest Mask and hand hygiene when feeding / handling (postnatal Care- patient information sheet)

Find it all here:

WCHN- Having a baby at the WCH
FMC- COVID-19 screening for maternity patients
LMH COVID-19 Birthing At Lyell Mc-Ewin Hospital
Regional- check with designated birthing hospital

GP Obstetric Shared Care

Perinatal Mental Health

- Recognition of depression and other mental health conditions is very important
- Use the Edinburgh Postnatal Depression Scale (EPDS) or other screening tool, to assess antenatal depression
- Screening of all women for Depression/ DV in the antepartum (at booking and at 28 weeks - using MBS item **16591**) and postpartum period using the EPDS

IMPORTANT CONTACT DETAILS

Assistance required with pregnancy care in covid + pregnant woman:

- Clinical advice
- Escalation of Care (F2F)
- VTE Prohpylaxis
- MAB Infusion (oral antivirals)

Contact details

- Birthing hospital
- SALHN COVID-19 Obstetrics DECT 82047898
- Birthing LHN in consultation with Obstetric Team
- www.sahealth.sa.gov/covidinfusion

COVID-19 & GP Obstetric Shared Care

Contact Numbers:

FMC Obstetric Dect phone: 82047898 24 hours
WCH: 81617000 pager 5899 24 hours
LMHS: 81829000 page 6146 mon- Friday 9.5pm after hours SALHN
CRCT:
Email Health.CRCTStatewide@sa.gov.au
GP contact to nurses 0401 577 241

Patient access 1800 272 872

GP Obstetric Shared Care- further info?

SA GP Obstetric Shared Care Protocols http://www.gppaustralia.org.au/

SA Perinatal Practice Guidelines www.health.sa.gov.au/ppg

OSC Midwife Coordinators/ GP Advisor
GP OSC Program Manager; Leanne March – (T): 0418 803 844

SA Health website – fact sheets

LHN websites-

- visitor guidelines
- COVID testing pre LSCS /IOL
- + partner/ support person
- Postnatal care

Guidelines; maternity pathway, SA Health, National Guidelines

THANKS FOR BEING AWESOME!

GPS ARE CORNERSTONE OF COVID COMMUNITY CARE

KEEP PROVIDING USUAL EXCELLENT PREGANACY CARE
VACCINATE, VACCINATE, VACCINATE
REMEMBER MAB & VTE
SUPPORT
LOOK OUT FOR RED FLAGS & REFER

GP Shared Care Obstetric

Thanks helping to keep SA & our OSC Pregnant women safe