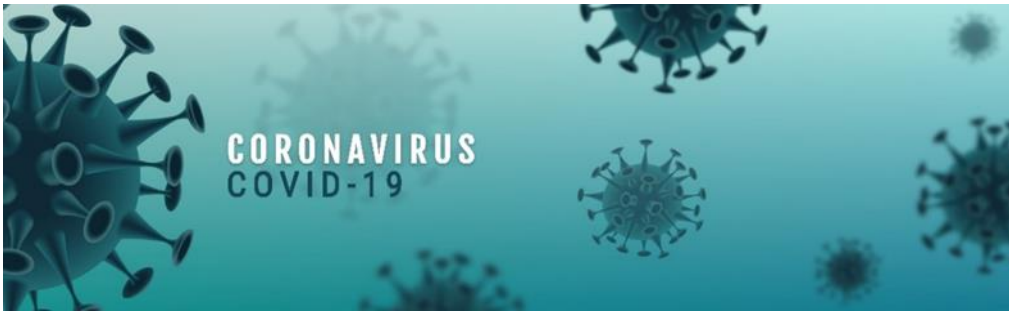
HTA Austria
Austrian Institute for
Health Technology Assessment
GmbH

Covid-19



HSS/ Horizon Scanning

Living Document **V13 April** 2021

HTA Austria
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Covid-19

HSS/ Horizon Scanning
Living Document **V13 April** 2021

Vienna, April 2021

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Dieser Bericht soll folgendermaßen zitiert werden/This report should be referenced as follows:
AIHTA Policy Brief Nr.: 002_V13 2021: Covid-19, HSS/ Horizon Scanning, Living Document April 2021.

Wien: HTA Austria – Austrian Institute for Health Technology Assessment GmbH.

Interessenskonflikt
Alle beteiligten AutorInnen erklären, dass keine Interessenskonflikte im Sinne der Uniform Requirements of Manuscripts Statement of Medical Journal Editors (www.icmje.org) bestehen.

IMPRESSUM

Medieninhaber und Herausgeber:

HTA Austria - Austrian Institute for Health Technology Assessment GmbH
Garnisongasse 7/Top20 | 1090 Wien – Österreich
www.aihta.ac.at

Für den Inhalt verantwortlich:
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Die **AIHTA Policy Briefs** erscheinen unregelmäßig und dienen der Veröffentlichung der Forschungsergebnisse des Austrian Institute for Health Technology Assessment.

Die **AIHTA Policy Briefs** erscheinen in geringer Auflage im Druck und werden über den Dokumentenserver „https://eprints.aihta.at/view/types/policy=5Fbrief.html" der Öffentlichkeit zur Verfügung gestellt.

AIHTA Policy Brief Nr.: 002

ISSN 2710-3234

ISSN online 2710-3242

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April 2021	Addition chapter on aviptadil (RLF-100) (chapter 3.29)
April 2021	Update Methodology (1.2)
April 2021	Update Vaccine (chapter 2)
April 2021	Update Remdesivir (chapter 3.1)
April 2021	Update Favipiravir (chapter 3.3)
April 2021	Darunavir (chapter 3.4) – no changes
April 2021	Camostat Mesilate (chapter 3.7) – no changes
April 2021	APN01/rhACE2 (chapter 3.8) – no changes
April 2021	Update Tocilizumab (chapter 3.9)
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April 2021	Update Interferon beta (chapter 3.11)
April 2021	Update Concalescent plasma (chapter 3.12)
April 2021	Update Plasma derived medicinal products (chapter 3.13) – REGN-COV2; LY-CoV555 and LY-CoV016; AZD7422; VIR-7831; regdanvimab
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April 2021	Solnatide (chapter 3.15) – no changes
April 2021	Umifenovir (chapter 3.16) – no changes
April 2021	Dexamethasone and other corticosteroids (chapter 3.17)
April 2021	Anakinra (chapter 3.18) – no changes
April 2021	Colchicine (chapter 3.19) – no changes
April 2021	Nafamostat (chapter 3.20) – no changes
April 2021	Gimsilumab (chapter 3.21) – no changes
April 2021	Canakinumab (chapter 3.22) – no changes
April 2021	Update Lenzilumab (chapter 3.23)
April 2021	Vitamin D (chapter 3.24) – no changes
April 2021	Baricitinib (chapter 3.25) – no changes
April 2021	Molnupiravir (chapter 3.26) – no changes
April 2021	Update Ivermectin (chapter 3.27)
April 2021	Aspirin (chapter 3.28) – no changes

1 Background: policy question and methods

1.1 Policy Question

On March 30th 2020, a request was raised by the Austrian Ministry of Health (BMASGK), the Health Funds of the Regions and the Federation of Social Insurances to set up a Horizon Scanning ystem (HSS) for medicines and vaccines. The establishment of a HSS/ Horizon Scanning System for Covid-19 interventions has the intentions of

a. informing health policy makers at an early stage which interventions (vaccinations and drugs) are currently undergoing clinical trials and
b. monitoring them over the next few months in order to support evidence-based purchasing, if necessary.

März 2020:
Österr. Politik empfiehlt Aufbau von HSS zu Covid-19

Information zu
*** Status F&E**
*** Evidenz-basierter Einkauf**

1.2 Methodology

To respond to this request,

1. As a first step an inventory, based on international sources, is built.
2. As a second step, selective searches by means of searches in study registries are carried out for information on clinical studies in humans and the state of research.
3. This information forms the basis for “vignettes” (short descriptions) for those products that are already in an "advanced" stage.
4. Subsequently, the products are monitored with regard to the status of the clinical studies up to approval and finally evaluated for their benefit and harm.

mehrstufige Methodik

Bestandsaufnahme
selektive Suche
Vignetten
Monitoring

All work steps are conducted in close international (European) cooperation.

- Version 1 (V1, April 2020): inventory + vignettes for most advanced
- Version 2+: monthly monitoring and updates

internationale/ europ. Zusammenarbeit

Ongoing trials are reported in V1, April 2020 - V3, June 2020 of this Document and in the living documents - EUnetHTA (Covid-19 Rolling Collaborative Reviews: https://eunethta.eu/rcr01-rcrxx/).

From V4 July, 2020 of this HSS/ Horizon Scanning Document, only completed, terminated, withdrawn and suspended interventional clinical trials from ClinicalTrials.gov and EUdraCT registers are reported. From Version 8 November, 2020 only terminated, withdrawn and suspended interventional clinical trials are reported.

From V5, August 2020 of this HSS/ Horizon Scanning Document only the best available evidence will be presented in.

V1-V3: auch laufende Studien - Verweis auf EUnetHTA
V4: nur abgeschlossene (oder beendete) Interventionsstudien aus 2 Studienregistern
ab V5: nur mehr best verfügbare Evidenz

Table 1.2-1: International Sources

Primary sources	Link
WHO Drugs: Vaccines:	https://www.who.int/teams/blueprint/covid-19 https://www.who.int/blueprint/priority-diseases/key-action/Table_of_therapeutics_Appendix_17022020.pdf?ua=1 https://www.who.int/who-documents-detail/covid-19-candidate-treatments https://www.who.int/who-documents-detail/draft-landscape-of-covid-19-candidate-vaccines
Danish Medicine Agency Drugs: Vaccines:	https://laegemiddelstyrelsen.dk/da/nyheder/temaer/ny-coronavirus-covid-19/~/media/5B83D25935DF43A38FF823E24604AC36.ashx https://laegemiddelstyrelsen.dk/da/nyheder/temaer/ny-coronavirus-covid-19/~/media/3A4B7F16D0924DD8BD157BBE17BFED49.ashx
Pang et al. 2020 [1] Drugs: Vaccines:	https://www.mdpi.com/2077-0383/9/3/623 Table 5+6, Table 3+4
SPS HS-report (UK)	unpublished
Secondary sources	
VfA/ Verband Forschender Arzneimittelhersteller Drugs: Vaccines:	https://www.vfa.de/de/arzneimittel-forschung/woran-wir-forschen/therapeutische-medikamente-gegen-die-coronavirusinfektion-covid-19 https://www.vfa.de/de/arzneimittel-forschung/woran-wir-forschen/impfstoffe-zum-schutz-vor-coronavirus-2019-ncov
EMA/ Europen Medicines Agency Medicines:	https://www.ema.europa.eu/ https://www.ema.europa.eu/en/medicines/medicines-under-evaluation
FDA/US Food and Drug Administration	https://www.fda.gov/emergency-preparedness-and-response/counterterrorism-and-emerging-threats/coronavirus-disease-2019-covid-19
Trial Registries	
US National Library of Medicine European Union Drug Regulating Authorities Clinical Trials Database WHO International Clinical Trials Registry Platform TrialsTracker	https://clinicaltrials.gov/ https://eudract.ema.europa.eu/ https://www.who.int/ictrp/en/ http://Covid-19.trialstracker.net/
Up-to-date information on clinical trials and literature searching resources relating to COVID-19	
Cochrane COVID-19 Study Register 21/04.20	https://covid-19.cochrane.org/
Living mapping of research and a living systematic review	https://covid-nma.com/ https://covid-nma.com/dataviz/
Dynamic meta-analysis of evidences about drug efficacy and safety for COVID19 - meta/Evidence – COVID-19	http://metaevidence.org/COVID19.aspx
CORDITE (CORona Drug InTEractions database)	https://cordite.mathematik.uni-marburg.de/#/
Living listing of interventional clinical trials in Covid-19/2019-nCoV produced by the Anticancer Fund	http://www.redo-project.org/covid19db/; http://www.redo-project.org/covid19_db-summaries/
Global Coronavirus COVID-19 Clinical Trial Tracker	https://www.covid-trials.org/
LitCovid	https://www.ncbi.nlm.nih.gov/research/coronavirus/
UK NIHR Innovation Observatory NIHR COVID-19 Studies COVID-19 Therapeutics Dashboard COVID-19: a living systematic map of the evidence	https://www.nihr.ac.uk/covid-studies/ http://www.io.nihr.ac.uk/report/covid-19-therapeutics/ http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=3765
WHO COVID-19 Database new search interface	https://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov
COVID-evidence Database	https://covid-evidence.org/database
Medical Library Association – COVID-19 Literature search strategies	https://www.mlanet.org/page/covid-19-literature-searching

Centre of Evidence Based Dermatology (CEBD) - Coronavirus Dermatology Online Resource	https://www.nottingham.ac.uk/research/groups/cebd/resources/Coronavirus-resource/Coronavirushom
Ovid Expert Searches for COVID-19	http://tools.ovid.com/coronavirus/
EBSCO Covid-19 Portal Literature searching section of portal Information portal	 https://covid-19.ebscomedical.com/research https://covid-19.ebscomedical.com/
NIH COVID-19 Treatment Guidelines. 2020.	https://covid19treatmentguidelines.nih.gov/introduction/
Tertiary sources	
NIPHNO	https://www.fhi.no/en/qk/systematic-reviews-hta/map/
INAHTA	http://www.inahta.org/covid-19-inahta-response/
EUnetHTA Covid-19 Rolling Collaborative Reviews (RCR)	https://eunethta.eu/rcr01-rcrxx/

"lebende" Dokumente mit up-to-date Informationen

Several organisations and international teams of researchers are providing up-to-date information through living listing of interventional clinical trials in Covid-19/2019-nCoV and literature resources (Table 1.2-1) [2-4] [2]. A short description of two of such databases is presented below.

Kartierung von laufenden RCTs

Boutron et al., 2020 [3] are performing a living mapping of ongoing randomized trials, followed by living systematic reviews with pairwise meta-analyses and when possible, network meta-analyses focusing on two main questions: the effectiveness of preventive interventions for COVID-19 and the effectiveness of treatment interventions for COVID-19 (Figure 1.2-1).

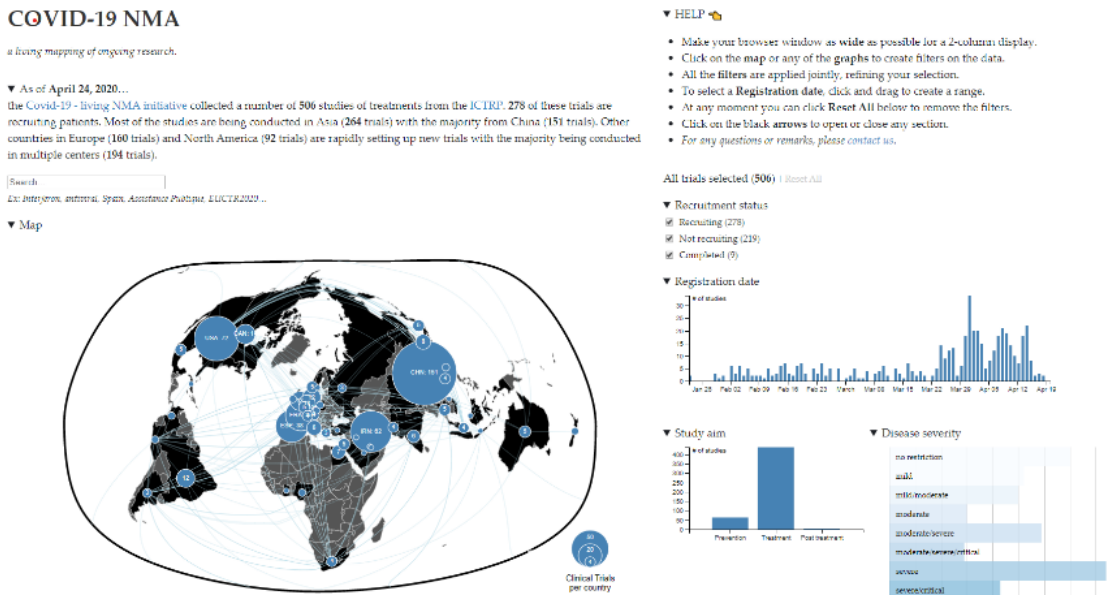

Figure 1.2-1: A living mapping of ongoing randomized trials, living systematic reviews with pairwise meta-analyses and network meta-analyses

Clinical Trial Tracker real-time dashboard

Thorlund et al., 2020 [4] developed a COVID-19 clinical trials registry to collate all trials related to COVID-19: Global Coronavirus COVID-19 Clinical Trial Tracker. Data is pulled from the International Clinical Trials Registry Platform, including those from the Chinese Clinical Trial Registry, ClinicalTrials.gov, Clinical Research Information Service - Republic of Korea, EU Clinical Trials Register, ISRCTN, Iranian Registry of Clinical Trials, Japan Primary Registries Network, and German Clinical Trials Register (Figure 1.2-2). They also use content aggregator services, such as LitCovid, to ensure that their data acquisition strategy is complete [5].

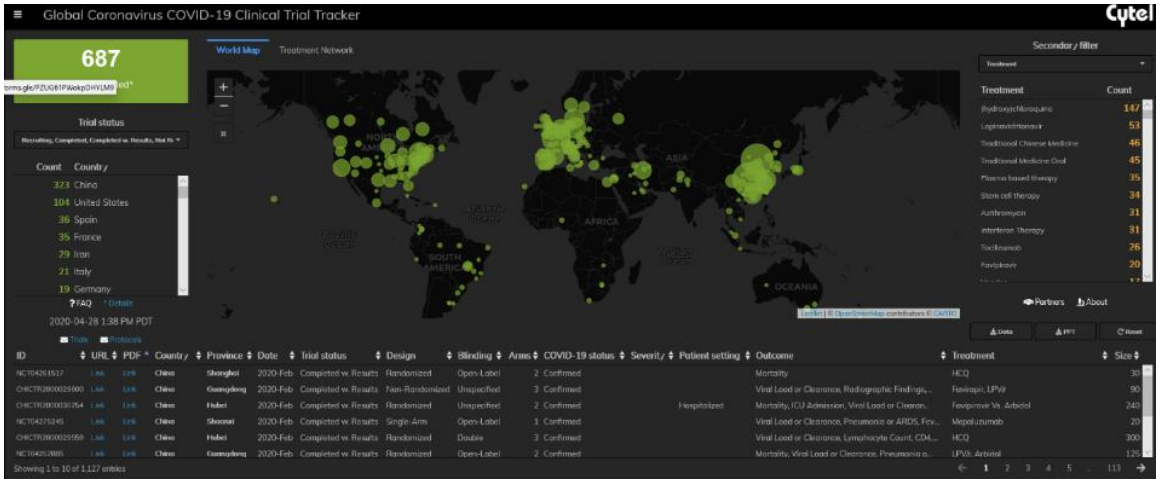

Figure 1.2-2: Global Coronavirus COVID-19 Clinical Trial Tracker - a real-time dashboard of clinical trials for COVID-19

1.3 Selection of Products for "Vignettes"

Vignetten zu Produkte, in "fortgeschrittenen" Stadien oder

häufig diskutiert/ publiziert
Regeln, wann das Monitoring beendet wird folgen EUnetHTA

The following products have been selected for further investigation (searches in registry databases and description as "vignettes") for the following reasons:

- most advanced in clinical research in humans
- most often discussed in clinical journals as potential candidates

Decision to stop further investigation will be based on modified EUnetHTA stopping rules, https://eunethta.eu/covid-19-treatment/: 1) the compound has a positive marketing authorization decision or 2) no clinical benefit: ≥ 2 RCTs OR treatment arms in platform trials (e.g., RECOVERY) with negative efficacy and/or safety results in the indication and population under review (phase III, of high or moderate quality/ high or moderate certainty of evidence, well powered) OR ≥1 RCT with negative efficacy and/or safety results in the indication and population under review (phase III, of high or moderate quality/ high or moderate certainty of evidence, well powered) AND stopped enrollment of participants to the treatment arm of interest in a platform trial (e.g., RECOVERY) because no evidence of beneficial effects.

The full inventory (list) can be found in Part 2 - Appendix A-1: vaccines, A-2, therapeutics, A3-EudraCT registry studies.

From January 2021 (v10) only vaccines for which the European Commission (EC) concluded contracts or exploratory talks with their manufactures, to build a diversified portfolio of COVID-19 vaccines for EU citizens, will be presented in detail.

v10: nur Impfstoffe, für die EC Verträge abgeschlossen hat/ abschließt

From April 2021 (V13) focuse will be also on COVID-19 vaccines which clinical trials are conducted in children, on vaccines effectiveness related to SARS-CoV-2 new variants as well as on COVID-19 intranasal vaccines in development.

ab April 2021: Fokus auf Impfungen für Kinder und auf Wirksamkeit bei unterschiedlichen Mutationen

2 Results: Vaccines

As of April 12, 2021, the **European Commission** (EC) has given the **conditional marketing authorisation** for the vaccines developed by **BioNTech and Pfizer – Comirnaty® (vaccine efficacy 94.6%)** on **21 December 2020**, and **Moderna – COVID-19 Vaccine Moderna (vaccine efficacy 94.1%)** on **6 January 2021**, following EMA positive assessment of its safety and efficacy.

Conditional Approval von EMA für 4 Impfstoffe:
BioNTech/ Pfizer
Moderna
AstraZeneca
Janssen/J&J

On **29 January 2021**, the EC has given the **conditional** marketing authorisation for the vaccine developed by **AstraZeneca – now Vaxzevria (previously COVID-19 Vaccine AstraZeneca) (vaccine efficacy around 60%).**

On **11 March 2021,** the **European Commission** (EC) has given the **conditional** marketing authorisation for the **COVID-19 Vaccine Janssen (vaccine efficacy 67%)** developed by **Janssen Pharmaceutica NV/Johnson & Johnson**, following evaluation by EMA.

On February 03 2021 CHMP has started a **rolling review** of **NVX-CoV2373**, a COVID-19 vaccine being developed by **Novavax** CZ AS (a subsidiary of Novavax, Inc.), and on February 12th a rolling review of **CVnCoV**, a COVID-19 vaccine being developed by **CureVac** AG [6, 7]. On March 4, 2021 CHMP has started a rolling review of **Sputnik V COVID-19** vaccine developed by **Russia's Gamaleya National Centre of Epidemiology and Microbiology** [8].

3 weitere in "Rolling Reviews" bei EMA:
Novavax
CureVac
Sputnik

As of April 12, 2021, the **EC** concluded **contracts with different vaccine manufactures** to build a diversified portfolio of COVID-19 vaccines for EU citizens: with **AstraZeneca** (400 million doses), **Sanofi-GSK** (300 million doses), **Johnson and Johnson/Janssen Pharmaceuticals** (400 million doses), **BioNTech-Pfizer** (600 million doses), **CureVac** (405 million doses) and **Moderna** (460 million doses). The EC has concluded **exploratory talks** with the pharmaceutical company **Novavax** with a view to purchasing up to 200 million doses and with **Valneva** with a view to purchase up to 60 million doses,
https://ec.europa.eu/commission/presscorner/detail/en/QANDA_20_2467.

EC Verträge mit 6 Firmen

2 weitere in Verhandlung:
Novavax
Valneva

As of April 12, **2021,** out of these eight **COVID-19 candidate vaccines contracted** or **exploratory talks** has concluded **for EU, three are investigate in phase 4, four are investigated in phase 3 RCTs, and one in phase 1/2 study:**

8 Impfstoffe:
3 in Phase 4
4 in Phase 3
1 in Phase 1/2

1. **Moderna Therapeutics/NIAID** (RNA LNP-encapsulated mRNA vaccine encoding S protein);
2. **University of Oxford/AstraZeneca** (Non-Replicating Viral Vector ChAdOx1 (AZD1222) vaccine);
3. **BioNTech/Fosun Pharma/Pfizer** (RNA 3 LNP-mRNAs vaccine); all in phase 4 RCTs;
4. **Janssen Pharmaceuticals/Johnson & Johnson** (Non-Replicating Viral Vector Ad26COVS1 vaccine);
5. **Novavax** (Protein Subunit, VLP-recombinant protein nanoparticle vaccine + Matrix M);
6. **CureVac** (RNA based vaccine, CVnCov2) vaccine,
7. **Sanofi-GSK** (Protein Subunit, with adjuvant 1 vaccine), all in phase 3 RCTs;
8. **Valneva** (Inactivated virus), in phase ½ study.

Out of these 8 coronavirus vaccines, the following articles were published for 7 vaccines, with results related to early phases vaccine trials (phase 1, 1/2 or phase 2) or phase 2/3 and phase 3 trials:

21-Publikationen zu Impfstudien

1. Three on **Moderna Therapeutics/NIAID** vaccine: a preliminary report with the results from the phase 1 study (NCT04283461) [9],
2. The results from the expanded phase 1 study (NCT04283461) in older adults [10] and
3. The results from phase 3 RCT (NCT04470427) [11];
4. Thee on **Novavax** vaccine: the results from the phase 1/2 RCT (NCT04368988) [12];
5. The results from phase 2 component of 1/2 RCT (NCT04368988) trial [13]; and
6. The preliminary results from phase 2a/b in South Africa (NCT04533399) [14];
7. Eight on **Oxford/Astra Zeneca** vaccine: a preliminary report with the results from phase 1/2 single-blind, RCT (ISRCTN 15281137/NCT04324606/EudraCT 2020-001072-15) [15],
8. A report from the same RCT, on subgroups of volunteeres who were subsequesntly allocated to recive a homologous full-dose or half-dose ChAdOx1 booster vaccine 56 d following prime vaccination [16],
9. Pooled interim analysis phase 2/3 trials (ISRCTN89951424, NCT04324606, NCT04400838, and NCT04444674) [17], and
10. Pooled primary analysis phase 2/3 trials (ISRCTN89951424, NCT04324606, NCT04400838, and NCT04444674) [18], and
11. Phase 2 component of phase 2/3 trial COV002 (ISRCTN90906759, NCT04400838) [19]; ~~and~~
12. Phase 3 component of phase 2/3 trials (ISRCTN89951424, NCT04324606, NCT04400838, and NCT04444674) [20];
13. Phase 3 trial in South Africa (NCT04444674) [21]
14. Exploratory analysis of a RCT (NCT04400838) [22]
15. Four on **BioNTech/Fosun Fharma/Pfizer** vaccine**:** Three with results from two phase 1/2 trials on **BNT162b1** vaccine, one in US (NCT04368728/EudraCT 2020-001038-36) [23], and
16. One in Germany (NCT04380701, EudraCT 2020-001038-36) [24] as well as
17. Additional safety and immunogenicity results from the US phase 1 trial (NCT04368728/EudraCT 2020-001038-36) [52, 53] and
18. One pivotal RCT efficacy trial on BNT162b2 (NCT04368728) [25] and
19. One on **Janssen Pharmaceuticals/Johnson & Johnson** vaccine**:** interim results of a **phase ½** trial (NCT04436276) [41];
20. One on **CureVac**: preliminary results of **phase 1** trial (NCT04449276) [26] and
21. One on **Sanofi and GSK**: interim results of phase ½ trial (NCT04537208) [27].

Regulatory Guidances and position paper:

Positionspapier der Internationalen Regulatoren zu Impfstudien

stringente klinische Studien vonnöten !

On 09/07/2020, Medicines Regulatory Authorities published the report related to phase 3 COVID-19 vaccine trials [28]. They stressed the need for large phase 3 clinical trials that enroll many thousands of people, including those with underlying medical conditions, to generate relevant data for the key target populations. Broad agreement was achieved that clinical studies should be designed with stringent success criteria that would allow a convincing demonstration of the efficacy of COVID-19 vaccines.

On November 11, 2020 EMA publishes safety monitoring plan and guidance on risk management planning for COVID-19 vaccines, https://www.ema.europa.eu/en/news/ema-publishes-safety-monitoring-plan-guidance-risk-management-planning-covid-19-vaccines.

EMA Publikation zu Sicherheitsdaten von Comirnaty®
gleich wie in klin. Studie

EMA released on 29 January 2021 its **first safety update** on a **COVID-19 vaccine — Comirnaty,** a vaccine produced by BioNTech and Pfizer. It concluded that safety data collected on Comirnaty use in vaccination campaigns was consistent with the known safety profile of the vaccine, and no new side effects were identified [29].

EMA Publikation zu Sicherheitsdaten von Moderna
keine Sicherheitsbedenken

On February 5, 2021 EMA released its **first safety update** on a **COVID-19 vaccine — Moderna**, a vaccine produced by Moderna Biotech Spain, S.L. This update presents the assessment of an investigation of reports of suspected severe allergic reaction coming from a single vaccination site in the United States. The assessment of these reports has not identified new aspects regarding the nature of this known side effect. The benefits of COVID-19 Vaccine Moderna in preventing COVID-19 continue to outweigh any risks, and there are no recommended changes regarding the use of the vaccine [30].

März 2021: EMA (PRAC) beginnt Untersuchung zu Nebenwirkungen von AstraZeneca

Thromboembolien

On April 7, 2021 EMA's safety committee (PRAC) has concluded that **unusual blood clots with low blood platelets** should be listed as very rare side effects of **Vaxzevria (formerly COVID-19 Vaccine AstraZeneca**). EMA is reminding healthcare professionals and people receiving the vaccine to remain aware of the possibility of very rare cases of blood clots combined with low levels of blood platelets occurring within 2 weeks of vaccination. So far, most of the cases reported have occurred in women under 60 years of age within 2 weeks of vaccination. Based on the currently available evidence, specific risk factors have not been confirmed. One plausible explanation for the combination of blood clots and low blood platelets is an immune response, leading to a condition similar to one seen sometimes in patients treated with heparin (heparin induced thrombocytopenia, HIT). The PRAC has requested new studies and amendments to ongoing ones to provide more information and will take any further actions necessary, https://www.ema.europa.eu/en/news/astrazenecas-covid-19-vaccine-ema-finds-possible-link-very-rare-cases-unusual-blood-clots-low-blood.

Anaphylaxis

Following the assessment of a safety signal regarding cases of **anaphylaxis** (severe allergic reactions) with **COVID-19 Vaccine AstraZeneca**, **PRAC has recommended** an **update to the product information** to **include anaphylaxis and hypersensitivity** (allergic reactions) as **side effects** in section 4.8, with an unknown frequency, and to **update the existing warning** to reflect that cases of anaphylaxis have been reported. The update is based on a review of 41 reports of possible anaphylaxis seen among around 5 million vaccinations in the United Kingdom. After careful review of the data, PRAC considered that a link to the vaccine was likely in at least some of these cases, https://www.ema.europa.eu/en/news/meeting-highlights-pharmacovigilance-risk-assessment-committee-prac-8-11-march-2021.

On April 9, 2021 PRAC has started a review of a safety signal to assess reports of **capillary leak syndrome** in people who were vaccinated with **Vaxzevria (previously COVID-19 Vaccine AstraZeneca).** Five cases of this very rare disorder, characterised by leakage of fluid from blood vesselscausing tissue swelling and a drop in blood pressure, were reported in the EudraVigilancedatabase. At this stage, it is not yet clear whether there is a causal association between vaccination andthe reports of capillary leak syndrome, https://www.ema.europa.eu/en/news/meeting-highlights-pharmacovigilance-risk-assessment-committee-prac-6-9-april-2021.

weiters: Kapillarlecksyndrom

neuer Name: Vaxzevria (AstraZeneca)

PRAC has **started a review of a safety signal** to assess reports of **immune thrombocytopenia** in patients who received any of the three COVID-19 vaccines: **Comirnaty, COVID-19 Vaccine AstraZeneca and COVID-19 Vaccine Moderna**.

PRAC Untersuchung von BioNTech, AstraZeneca und Moderna zu Thrombozytopenie

PRAC has **started a review of a safety signal** to assess reports of **localised swelling after vaccination with COVID-19 vaccine Comirnaty** in people with a **history of injections with dermal fillers** (soft, gel-like substances injected under the skin), https://www.ema.europa.eu/en/news/meeting-highlights-pharmacovigilance-risk-assessment-committee-prac-8-11-march-2021.

BioNTech: Schwelling an Einstichstelle

On April 9, 2021 PRAC has started a review of a safety signal to assess reports of **thromboembolic events** (formation of blood clots, resulting in the obstruction of a vessel) in people whoreceived **COVID-19 Vaccine Johnson & Johnson (Janssen)**. Four serious cases of unusual blood clots with low blood platelets have been reported post-vaccination with COVID-19 Vaccine Janssen. One case occurred in a clinical trial and threecases occurred during the vaccine rollout in the USA. One of them was fatal, https://www.ema.europa.eu/en/news/meeting-highlights-pharmacovigilance-risk-assessment-committee-prac-6-9-april-2021.

PRAC Untersuchung von Johnson & Johnson

Thromboembolien

On April 13, 2021 FDA and CDC are recommending a pause in the use of **Johnson & Johnson (Janssen)** COVID-19 vaccine out of an abundance of caution. They are reviewing data involving six reported U.S. cases of a rare and severe type of blood clot in individuals after receiving the J&J vaccine. In these cases, a type of blood clot called cerebral venous sinus thrombosis (CVST) was seen in combination with low levels of blood platelets (thrombocytopenia). All six cases occurred among women between the ages of 18 and 48, and symptoms occurred 6 to 13 days after vaccination. Treatment of this specific type of blood clot is different from the treatment that might typically be administered. Usually, an anticoagulant drug called heparin is used to treat blood clots. In this setting, administration of heparin may be dangerous, and alternative treatments need to be given, https://www.fda.gov/news-events/press-announcements/joint-cdc-and-fda-statement-johnson-johnson-covid-19-vaccine.

FDA: Pausierung von Impfung mit Johnson & Johnson

On February 10, 2021 **EMA** stated that it is **developing guidance for manufacturers planning changes to the existing COVID-19 vaccines** to tackle the **new virus variants**. In order to consider options for additional testing and development of vaccines that are effective against new virus mutations, the Agency has requested all vaccine developers to investigate if their vaccine can offer protection against any new variants, e.g., those identified in the United Kingdom - variant called **B.1.1.7**, South Africa - **B.1.351** and Brazil - variant called **P.1**, and submit relevant data. EMA will shortly publish a reflection paper that will set out the data and studies needed to support adaptations of the existing vaccines to current or future mutations of SARS-CoV-2 in the European Union (EU). There are concerns that some of these mutations could impact to different degrees the ability of the vaccines to protect against

EMA Guidance für Vazzinehersteller bez. Veränderungen wegen Mutanten

B.1.1.7 (UK)
B.1.351 (SA)
P.1 (BR)

infection and disease. A reduction in protection from mild disease would however not necessarily translate into a reduction in protection from serious forms of the disease and its complications, for which Agency need to collect more evidence [31].

Vaccine and SARS-CoV-2 variants

Impfwirksamkeit bei Mutationen in Tabelle 2-2

So far, studies suggest that effectiveness may be reduced aginst some SARS-CoV-2 variants and more data are needed [14, 22, 32-45]. Current data related to clinical effectiveness and in vitro neutralisation, on **B.1.1.7, B.1.351** and **P.1 SARS-CoV-2 variants** can be found in Table 2-2. Updated vaccines will be necessary to eliminate the virus. Recently, in addition to B.1.1.7, B.1.351 and P.1, two more SARS-CoV-2 variants, **B.1.427** and **B.1.429,** which were first detected in California, have been shown to be approximately 20% more transmissible than preexisting variants and have been classified by the CDC as variants of concern.

Vaccine in development in children

klinische Studien zu Pfizer, Moderna, AstraZeneca, Johnson &Johnson, Sinovac bei Kindern in Tabelle 2-3

Clinical trials are currently under way to test the Pfizer, Moderna, Oxford-AstraZeneca, Jansenn/Johnson&Johnson and Sinovac vaccines in children [46-50] Details can be found in Table 2-3.

Intranasal vaccines in development

intranasale Verabreichung in Tabelle 2-4

As of 09 April 2021, seven COVID-19 intranasal vaccines in development were found. Nasal delivery is easier for administration, without needles and and can be self administered. Intranasal vaccines could boost immune defenses in mucosa. As example, Oxford is launching a phase 1 trial of a nasal spray COVID-19 vaccine, including 30 volunteers aged 18-40. The spray will use the same ChAdOx1 nCoV-19 compound as the AstraZeneca shot. Details can be found in Table 2-4.

*Table 2-1: Vaccines contracted or **exploratory talks** have concluded for EU, in the R&D pipeline (Phase 1 - Phase 4 clinical trials, not preclinical stages), April 9, 2021*

Source: Adapted from DRAFT landscape of COVID-19 candidate vaccines – April 9 2021, https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines and Creech et al. 2021 [51]

Developers	Vaccine / Vaccine type	Number of doses	Study phase	Storage conditions	Efficacy against severe COVID-19	Overall efficacy	EC (EU) Current approval or EMA "rolling review"
Moderna + National Institute of Allergy and Infectious Diseases (NIAID)	**COVID-19 Vaccine Moderna (mRNA -1273) / m RNA**	2 IM	Phase 4	-25° to -15°C; 2-8°C for 30 d; room temperature ≤12 h	100% 14 d after 2nd dose	92.1% after 1st dose; 94.1% 14 d after 2nd dose	**Conditional marketing authorisation**
AstraZeneca + University of Oxford	**COVID-19 Vaccine AstraZeneca (ChAdOx1-S - (AZD1222) / Viral vector**	2 IM	Phase 4	2-8° C for 6 mo	100% 21 d after 1st dose	64.1% after 1st dose; 70.4% 14 d after 2nd dose	**Conditional marketing authorisation**
BioNTech + Pfizer	**Comirnaty (BNT162b2) / mRNA**	2 IM	Phase 4	-80° to -60°C; 2-8° C for 5 d; room temperature ≤2 h	88.9% after 1st dose	52% after 1st dose; 94.6% 7 d after 2nd dose	**Conditional marketing authorisation**
Janssen Pharmaceutical/Johnson&Johnson	**COVID-19 Vaccine Janssen (Ad26.COV2.S) / Viral vector**	1 IM	Phase 3	-25°C to -15°C; 2-8° C for 3 mo	85% after 28 d; 100% after 49 d	72% in US; 66% in Latin America; 57% in South Africa (at 28 d)	**Conditional marketing authorisation**
CureVac AG	**CVnCoV / mRNA**	2 IM	Phase 3	2-8° C for 3 mo; room temperature for 24 h	Unknown	Phase 3 ongoing	**EMA "rolling review"**
Sanofi Pasteur + GSK	**VAT00002**; SARS-CoV-2 vaccine formulation 1 with adjuvant 1 (S protein (baculovirus production) / **Protein subunit**	2 IM	Phase 3	2-8° C	N.A - Phase 2b ongoing	N.A - Phase 2b ongoing	N.A - Phase 2b ongoing
Novavax	**NVX-CoV2373 / Protein subunit**	2 IM	Phase 3	2-8° C for 6 mo	100%	89.3% in UK after 2nd dose; 60% in South Africa	**EMA "rolling review"**
Valneva	**VLA2001 / Inactivated virus**	2 IM	Phase 1/2	2-8° C	N.A – Phase 1 /2 ongoing	N.A – Phase 1 /2 ongoing	N.A - Phase 1 /2 ongoing

Table 2-2: SARS-CoV-2 variants and vaccines contracted or exploratory talks have concluded for EU, and some vaccines not contracted nor exploratory talks have concluded for EU: clinical effectiveness and in-vitro neutralisation

Developers	Vaccine / Vaccine type	Clinical Efficacy against B.1.1.7. (UK) / Neutralisation	Clinical Efficacy against B.1.351 (South Africa) / Neutralisation	Clinical Efficacy against P.1 (Brazil) / Neutralisation	Are updated versions being made to target variants?
Vaccines contracted or exploratory talks have concluded for EU					
Moderna + National Institute of Allergy and Infectious Diseases (NIAID)	COVID-19 Vaccine Moderna (mRNA -1273) / m RNA	Not yet available Decrease by 1.8x	Not yet available Decrease by ≤8.6x	Not yet available Decrease by 4.5x	Yes
AstraZeneca + University of Oxford	COVID-19 Vaccine AstraZeneca (ChAdOx1-S - (AZD1222) / Viral vector (Non-replicating)	70.4% against symptomatic COVID-19 Decrease by 9x	10.4% against symptomatic COVID-19 Decrease by ≤86× to complete immune escape	Not yet available Decrease by 2.9x	Yes
BioNTech + Pfizer	Comirnaty (BNT162b2) / mRNA	Real-word data: 72% (95% CI 58-86) 21 days after first dose and 86% (95% CI 76-97) seven days after two doses Decrease by 2x	100% in South Africa Decrease by ≤6.5x to 10.3x	Not yet available Decrease by 2.6X, 6.7x to 14x	Yes
Janssen Pharmaceutical/Johnson&Johnson	COVID-19 Vaccine Janssen (Ad26.COV2.S) / Viral vector (Non-replicating)	Not yet available	57% against moderate to severe COVID-19; 85% against severe COVID-19 and hospitalisation Not yet available	68.1% against moderate to severe disease Not yet available	Not yet available
CureVac AG	CVnCoV / mRNA	Not yet available	Not yet available (Strong results variant when tested on mice; CureVac would expand a trial in Europe and Latin America to analyse the vaccine's efficacy against select variants)	Not yet available	Not yet available
Sanofi Pasteur + GSK	VAT00002; SARS-CoV-2 vaccine formulation 1 with adjuvant 1 (S protein (baculovirus production) / Protein subunit	Not yet available	Not yet available	Not yet available	Not yet available
Novavax	NVX-CoV2373 / Protein subunit	89.3% against symptomatic COVID-19 Decrease by 1.8x	60% against symptomatic COVID-19	Not yet available	Yes
Valneva	VLA2001 / Inactivated virus	Not yet available	Not yet available	Not yet available	Not yet available
Vaccines not contracted nor exploratory talks have concluded for EU					
CoronaVac (Sinovac)	CoronaVac; SARS-CoV-2 vaccine (inactivated) / Inactivated virus	Decreased by 0.5X	Decrease 2.5 to 3.3x to complete or partial loss of neutralization	Not yet available	Not yet available
Brazil		Not yet available	Not yet available	Not yet available	Not yet available
Turkey		Not yet available	Not yet available	Not yet available	Not yet available

BBIBP-CorV (Sinopharm)	Inactivated SARS-CoV-2 vaccine (Vero cell) / Inactivated virus	Not yet available	Not yet available Complete or partial loss of neutralization	Decrease by 1.6x	Not yet available
Gamaleya (Sputnik V)	Gam-COVID-Vac Adeno-based (rAd26-S+rAd5-S) / Viral vector (Non-replicating)	Not yet available Not decreased	Not yet available Decrease 6.1X	Not yet available Decrease 2.8X	Not yet available

Table 2-3: COVID-19 Vaccines in development in children

Developers	Vaccine / Vaccine type	
Moderna + National Institute of Allergy and Infectious Diseases (NIAID)	COVID-19 Vaccine Moderna (mRNA - 1273) / m RNA	**NCT04796896 (KidCOVE)** Phase 2/3 RCT in 6,750 children ages 6 months through 11 years in U.S. and Canada Two parts: 1. **Part 1**: open label, dose-escalation, age de-escalation study. 2 yo – up to 12 yo: each participant may receive either 50 µg or 100 µg dose of the vaccine. 6 mo – up to 2 yo: each participant may receive either 25 µg, 50 µg, or 100 µg dose. 2. **Part 2**: randomised, observer-blind, placebo-controlled expansion study based on the preliminary evaluation of the Part 1 results. The participants will receive two doses of the vaccine 28 days apart. To evaluate the medicine's safety, tolerability, reactogenicity and effectiveness, the company will observe the participants for 12 months after the second jab. **NCT 04649151 (TeenCOVE)** Phase 2/3 RCT, to evaluate the safety, reactogenicity, and effectiveness of mRNA-1273 SARS CoV 2 vaccine in 3000 healthy adolescents 12 to <18 years of age in US
AstraZeneca + University of Oxford	COVID-19 Vaccine AstraZeneca (ChAdOx1-S - (AZD1222) / Viral vector	Phase 2 RCT in 300 **children aged 6-17**, in UK Currently has been **paused** while the **EMA** investigates the link between the shot and rare blood clots
BioNTech + Pfizer	Comirnaty (BNT162b2) / mRNA	**NCT 04368728 Phase 2/3 RCT in 2200 volunteers ages 12 to 15** On March 31, 2021 announced adolescent trials have shown efficacy of 100% in protecting adolescents ages 12-15, with no significant safety concerns. About 2,260 adolescents ages 12-15 years participated in the trial, with roughly half receiving the vaccine and half receiving a placebo. There were 18 cases of COVID-19 reported, all within the placebo group. One month after a second dose, the vaccine elicited SARS-CoV-2-neutralizing antibody geometric mean titers of 1,239.5 in a subset of adolescents, compared to 705.1 in an earlier group of 16- to 25-year-olds, according to the news release. The companies plan to submit these data to the U.S. Food and Drug Administration (FDA) and the European Medicines Agency (EMA) as soon as possible to request expansion of the Emergency Use Authorization (EUA) and EU Conditional Marketing Authorization for BNT162b2 **NCT 04816643, Phase 1/2/3 Study in 4644 children 6 months to 11 years old in US** Evaluating the safety, tolerability, and immunogenicity of the Pfizer-BioNTech COVID-19 vaccine on a two-dose schedule (approximately 21 days apart) in three age groups: children aged 5 to 11 years, 2 to 5 years, and 6 months to 2 years. The 5 to 11 year-old cohort started dosing last week and the companies plan to initiate the 2 to 5 year-old cohort next week. https://www.pfizer.com/news/press-release/press-release-detail/pfizer-biontech-announce-positive-topline-results-pivotal?linkId=114996658
Janssen Pharmaceutical/Johnson&Johnson	COVID-19 Vaccine Janssen (Ad26.COV2.S) / Viral vector	RCT, phase 2a Has begun in April 2021 testing its Covid-19 vaccine in 1700 adolescents aged 12; Initially will be tested in a small number of adolescents aged 16-17 years (following the review of initial data in this phase 2a trial, the study will be expanded to a larger group of younger adolescents in a stepwise approach).

		Currently enrolling participants in Spain and the United Kingdom; enrollment will commence shortly in the United States, the Netherlands and Canada, with Brazil and Argentina to follow https://www.wsj.com/articles/j-j-starts-testing-covid-19-vaccine-in-adolescents-11617379165
CureVac AG	CVnCoV / mRNA	Not available
Sanofi Pasteur + GSK	VAT00002; SARS-CoV-2 vaccine formulation 1 with adjuvant 1 (S protein (baculovirus production) / Protein subunit	Not available
Novavax	NVX-CoV2373 / Protein subunit	Pediatric and adolescent arms of the trials expected to initiate later in the second quarter 2021 https://www.marketwatch.com/story/novavax-to-expand-covid-19-vaccine-trials-to-children-teens-2021-04-05
Valneva	VLA2001 / Inactivated virus	Not available
Sinovac Biotech	CoronaVac; SARS-CoV-2 vaccine (inactivated) / Inactivated virus	**RCT on 500 children in China ages 3 to 17; preliminary results from phase ½ trials announced** safe and could induce immune responses among children and adolescents; The lower dose of the vaccine could induce favourable antibody responses in children aged three to 11 years while the medium dose worked well for those aged 12 to 17 years. https://www.clinicaltrialsarena.com/news/sinovac-vaccine-immune-responses-children/

Table 2-4: Intranasal vaccine in development

Developers	Vaccine platform	Vaccine type	No of doses	Study Phase	Registry number
AstraZeneca + University of Oxford	Viral vector (Non-replicating)	ChAdOx1-S - (AZD1222) (Covishield)	1-2	1	NCT04816019
University of Hong Kong, Xiamen University and Beijing Wantai Biological Pharmacy	Viral vector (Replicating)	DelNS1-2019-nCoV-RBD-OPT1 (Intranasal flu-based-RBD)	2	2	ChiCTR2000039715
Codagenix/Serum Institute of India	Live attenuated virus	COVI-VAC	1-2	1	NCT04619628
Center for Genetic Engineering and Biotechnology (CIGB)	Protein subunit	CIGB-669 (RBD+AgnHB)	3	1/2	RPCEC00000345
Altimmune, Inc.	Viral vector (Non-replicating)	AdCOVID, Adenovirus-based platform expresses the receptor-binding domain (RBD) of the Sars-Cov-2 spike protein	1-2	1	NCT04679909
Bharat Biotech International Limited	Viral vector (Non-replicating)	BBV154, Adenoviral vector COVID-19 vaccine	1	1	NCT04751682
Meissa Vaccines, Inc.	Live attenuated virus	MV-014-212, a live attenuated vaccine that expresses the spike (S) protein of SARS-CoV-2	3	1	NCT04798001

Source: Adapted from DRAFT landscape of COVID-19 candidate vaccines – April 9 2021, https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines

2.1 Moderna Therapeutics—US National Institute of Allergy

About the vaccine

mRNA-1273 collab mit NIAID/CEPI

The **mRNA-1273** vaccine candidate developed by ModernaTX, Inc. in collaboration with NIAID and sponsored by NIAID/CEPI is an LNP-encapsulated mRNA-based vaccine (mRNA-1273) intended for prevention through full-length, perfusion stabilized spike (S) protein of SARS-CoV-2 that is the key into the human cell [52].

Conditional marketing authorisation in EU

vorläufige Zulassung am 6. Jänner 2021

The **European Commission** has given the **conditional marketing authorisation** for the Moderna vaccine (**COVID-19 Vaccine Moderna**) on **6 January 2021**, following EMA positive assessment of its safety and efficacy. Vaccine demonstrated a **94.1% efficacy** in the trial, with 90.9% efficacy in participants at risk of severe COVID-19, including those with chronic lung disease, heart disease, obesity, liver disease, diabetes or HIV infection.

≥ 18 Jahre, 2 Dosen in Interval von 28 Tagen

It is **indicated** for active immunisation to prevent COVID-19 caused by SARS-CoV-2 in individuals 18 years of age and older, as a course of 2 doses (0.5 mL each). It is recommended to administer the second dose 28 days after the first dose. There are no data available on the interchangeability of COVID-19 Vaccine Moderna with other COVID-19 vaccines to complete the vaccination course. Individuals who have received the first dose of COVID-19 Vaccine Moderna should receive the second dose of COVID-19 Vaccine Moderna to complete the vaccination course. Individuals may not be fully protected until 14 days after their second dose. Contraindications are hypersensitivity to the active substance or to any of the excipients listed in SmPC document [53].

Nebenwirkungen

The **most frequently reported adverse reactions** were pain at the injection site (92%), fatigue (70%), headache (64.7%), myalgia (61.5%), arthralgia (46.4%), chills (45.4%), nausea/vomiting (23%), axillary swelling/tenderness (19.8%), fever (15.5%), injection site swelling (14.7%) and redness (10%). Adverse reactions were usually mild or moderate in intensity and resolved within a few days after vaccination. A slightly lower frequency of reactogenicity events was associated with greater age. Overall, there was a higher incidence of some adverse reactions in younger age groups: the incidence of axillary swelling/tenderness, fatigue, headache, myalgia, arthralgia, chills, nausea/vomiting and fever was higher in adults aged 18 to <65 years than in those aged 65 years and above. Local and systemic adverse reactions were more frequently reported after Dose 2 than after Dose 1. Anaphylaxis has been reported. Appropriate medical treatment and supervision should always be readily available in case of an anaphylactic reaction following administration of the vaccine. Close observation for at least 15 minutes is recommended following vaccination. The second dose of the vaccine should not be given to those who have experienced anaphylaxis to the first dose of COVID-19 Vaccine Moderna.

Dauer des Schutzes noch unbekannt

The **duration of protection** afforded by the vaccine is unknown as it is still being determined by ongoing clinical trials. Vaccine should be **stored** in a freezer frozen between -25°C to -15°C (shelf life unopened vial: 7 months). The unopened vaccine may be stored refrigerated at 2°C to 8°C, protected from light, for maximum 30 days. Once thawed the vaccine should not be re-

frozen. The unopened vaccine may be stored at 8°C to 25°C up to 12 hours after removal from refrigerated conditions [53].
Efficacy and safety results from phase 3 RCT are published by Baden et al. 2020 [11].

Phase 1:
45 gesunde Erwachsene
Juni 2021

Phase 1 trial with 45 healthy participants (NCT04283461) is ongoing. Participants are split to 3 groups where they receive two injections of low (25 mcg), medium (100 mcg) or high doses (250 mcg) of mRNA-1273 and are monitored for any AEs and immune response [54]. The Phase I safety study should be completed by June 2021.

Phase 2a:
bis August 2021

A **phase 2a**, randomized, observer-blind, placebo controlled, dose-confirmation study to evaluate the safety, reactogenicity, and immunogenicity of mRNA-1273 vaccine in adults aged 18 years and older (NCT04405076) is underway. This Phase 2 study should be completed by August 2021.

Phase 3 Studienprotokoll
RCT mt ca 30.000
Teilnehmer*innen

The randomized, **phase 3,** 1:1 placebo-controlled trial is currently ongoing (NCT04470427). It is expected to include approximately 30,000 participants enrolled in the U.S.

Moderna arbeitet an
2 an Mutanten
angepassten
Impfstoffvarianten

Moderna has **announced** that it is developing **two new approaches to emerging variants of covid-19** after studies showed that its vaccine had a reduced level of neutralising titres to the South African variant, suggesting that immunity might wane. Although the studies showed that Moderna's current vaccinewas effective against both the UK and South African variants, a sixfold reduction was seen in neutralising titre levels to the South African variant. In the first approach Moderna said that it would see whether a third "booster dose" of the current mRNA-1273 vaccine added to the approved two dose regimen would further increase neutralising titres against the emerging variants. In a second approach the company said that it had developed a booster vaccine candidate called mRNA-1273.351 against the emerging South African variant. It said that it was beginning phase I studies in the US to see whether this modified vaccine with variant specific proteins would increase the immunological effect [55].

2.2 University of Oxford/ Astra Zeneca

About the vaccine

ChAdOx1 nCoV-19,
seit April Vaxzevria

The **ChAdOx1 nCoV-19** (AZD1222, AstraZeneca licensed from Oxford University) vaccine candidate developed by the Jenner Institute at Oxford University is based on a non-replicating viral vector. A chimpanzee adenovirus platform is hereby used [56, 57]. The vaccine candidate uses a genetically modified safe adenovirus that may cause a cold-like illness. The intended prevention is through the modified adenovirus producing Spike proteins, eventually leading to the formation of antibodies to the coronavirus's Spike proteins [56].

Conditional marketing authorisation in EU

vorläufige Zulassung in
EU am 29. Jänner 2021

On 29 January 2021, the **EC** has given the **conditional marketing authorisation** for the vaccine developed by AstraZeneca – now **Vaxzevria,** previously **COVID-19 Vaccine AstraZeneca (vaccine efficacy around 60%).**

Vaccine is **indicated** for active immunisation to prevent COVID-19 caused by SARS-CoV-2, in individuals 18 years of age and older. The COVID-19 Vaccine AstraZeneca vaccination course consists of two separate doses of 0.5 ml each. The second dose should be administered between 4 and 12 weeks (28 to 84 days) after the first dose. There are no data available on the interchangeability of COVID-19 Vaccine AstraZeneca with other COVID-19 vaccines to complete the vaccination course. Individuals who have received the first dose of COVID-19 Vaccine AstraZeneca should receive the second dose of COVID-19 Vaccine AstraZeneca to complete the vaccination course. Protection starts from approximately 3 weeks after the first dose of COVID-19 Vaccine AstraZeneca. Individuals may not be fully protected until 15 days after the second dose is administered. As with all vaccines, vaccination with COVID-19 Vaccine AstraZeneca may not protect all vaccine recipients. Currently available clinical trial data do not allow an estimate of vaccine efficacy in subjects over 55 years of age.

≥ 18 Jahre,
2 Dosen in Interval von 4 bis 12 Wochen

Impfschutz beginnt ca nach 3 Wochen

zuwenig Daten für Aussagen zum Impfschutz bei ≥ 55 Jahre

Contraindications are hypersensitivity to the active substance or to any of the excipients listed in SmPC document [58]. The **most frequently reported adverse reactions** were injection site tenderness (63.7%), injection site pain (54.2%), headache (52.6%), fatigue (53.1%), myalgia (44.0%), malaise (44.2%), pyrexia (includes feverishness (33.6%) and fever >38°C (7.9%)), chills (31.9%), arthralgia (26.4%) and nausea (21.9%). The majority of adverse reactions were mild to moderate in severity and usually resolved within a few days of vaccination. When compared with the first dose, adverse reactions reported after the second dose were milder and reported less frequently. On April 9, 2021, EMA published the updated product information following endorsement of PRAC's recommendations by CHMP and the European Commission, related to possible link to very rare cases of unusual blood clots with low blood platelets, https://www.ema.europa.eu/en/medicines/human/EPAR/vaxzevria-previously-covid-19-vaccine-astrazeneca.

Nebenwirkungen

The **duration of protection** afforded by the vaccine is unknown as it is still being determined by ongoing clinical trials. Vaccine should be **stored** in a refrigerator (2°C – 8°C).

Dauer des Impfschutzes: unbekannt

Currently, the first clinical **phase 1/2** single-blinded, placebo-controlled, multi-centre randomised controlled trial to test efficacy, safety and immunogenicity of ChAdOx1 nCoV-19 in 510 healthy adults is ongoing (ISRCTN 15281137/NCT04324606/EudraCT 2020-001072-15). The primary endpoints are number of virologically confirmed symptomatic cases/symptomatic cases of COVID-19 (efficacy) and occurrence of serious adverse events (safety), measured within six months and an optional follow-up visit is offered at day 364. The study is estimated to be completed in May 2021 [59].

Phase 1/2:
510 gesunde Erwachsene

bis Mai 2021

Phase 2b/3 study (EUdraCT 2020-001228-32/NCT04400838) is ongoing; the primary endpoint is virologically confirmed (PCR positive) symptomatic COVID-19 infection.

Phase 2b/3 :
laufend

Phase 3 RCT (ISRCTN89951424) is ongoing in Brazil and South Africa, with another country in Africa set to follow, as well as a trial in the US (NCT04516746) [60]. Participants are randomly allocated to receive the investigational vaccine or a well-established meningitis vaccine. Volunteers will be followed for 12 months, and they will be tested for COVID-19 if they develop any symptoms which may represent COVID-19 disease[61]. The study is estimated to be completed in July 2021.

Phase 3 RCT
Brazilien, Südafrika, USA
12-Monate Follow-Up

Ende Juli 2021

Madhi et al. 2021 [21] published results from **RCT** (NCT04444674) **in South Africa.** Participants 18 to less than 65 years of age were assigned in a 1:1 ratio to receive two doses of vaccine containing 5×1010 viral particles or placebo (0.9% sodium chloride solution) 21 to 35 days apart. Serum samples obtained from 25 participants after the second dose were tested by pseudovirus and live-virus neutralization assays against the original D614G virus and the B.1.351 variant. The primary end points were safety and efficacy of the vaccine against laboratory-confirmed symptomatic coronavirus 2019 illness (Covid-19) more than 14 days after the second dose. Both the pseudovirus and the live-virus neutralization assays showed greater resistance to the B.1.351 variant in serum samples obtained from vaccine recipients than in samples from placebo recipients. In the primary end-point analysis, mild-to-moderate Covid-19 developed in 23 of 717 placebo recipients (3.2%) and in 19 of 750 vaccine recipients (2.5%), for an efficacy of 21.9% (95% confidence interval [CI], −49.9 to 59.8). Among the 42 participants with Covid-19, 39 cases (92.9%) were caused by the B.1.351 variant; vaccine efficacy against this variant, analyzed as a secondary end point, was 10.4% (95% CI, −76.8 to 54.8). The incidence of serious adverse events was balanced between the vaccine and placebo groups. two-dose regimen of the ChAdOx1 nCoV-19 vaccine did not show protection against mild-to-moderate Covid-19 due to the B.1.351 variant.

RCT (Südafrika)
1467 Geimpfte
geringe Wirksamkeit gegen B.1.351

Emary et al. 2021 [22] published results from **post-hoc analysis** of the efficacy of the adenoviral vector vaccine, ChAdOx1 nCoV-19 (AZD1222), revealed that laboratory virus neutralization activity by vaccine-induced antibodies was lower against B.1.1.7. However, clinical vaccine efficacy against symptomatic NAAT positive infection was good, with 70% (95% CI 44–85) for B.1.1.7 and 82% (68–89) for other lineages.

post-hoc Analyse:
geringere Wirksamkeit gegen B.1.1.7 (70%) als gegen andere Mutationen (82%)

2.3 BioNTech/Fosun Pharma/Pfizer

About the vaccine

The **BNT-162** vaccine candidate developed by BioNTech in collaboration with Fosun Pharma and Pfizer is an mRNA platform-based vaccine expressing codon-optimized undisclosed SARS-CoV-2 protein(s) encapsulated in 80-nm ionizable cationic lipid/ phosphatidylcholine/ cholesterol/ polyethylene glycol–lipid nanoparticles [62].

BNT-162

Conditional marketing authorisation in EU

The **European Commission** has given the **conditional marketing authorisation** for the vaccines developed by BioNTech and Pfizer (Comirnaty vaccine, a COVID-19 mRNA vaccine, BioNTech Manufacturing GmbH/Pfizer Manufacturing Belgium NV, previously BNT162b2,) on **21 December 2020**, following EMA positive assessment of its safety and efficacy. Vaccine **efficacy** in the trial was **94.6**%, with similar efficacy point estimates across genders, ethnic groups, and participants with medical comorbidities associated with high risk of severe COVID-19.

vorläufige Zulassung in EU am 21. Dezember 2020

Comirnaty® is **indicated** for active immunisation to prevent COVID-19 caused by SARS-CoV-2 virus, in **individuals 16 years of age and older**. Each vial contains 6 doses of the vaccine. Comirnaty is administered intramuscularly after dilution as a course of **2 doses** (0.3 mL each) at least 21

Comirnaty®
≥ 16 Jahre,
2 Dosen in Interval von 21 Tagen

days apart. There are no data available on the interchangeability of Comirnaty with other COVID-19 vaccines to complete the vaccination course. Individuals who have received 1 dose of Comirnaty should receive a second dose of Comirnaty to complete the vaccination course. Comirnaty should be administered intramuscularly.

Nebenwirkungen

Contraindications are hypersensitivity to the active substance or to any of the excipients (ALC-0315, ALC-0159, DSPC, cholesterol, potassium chloride, potassium dihydrogen phosphate, sodium chloride, disodium phosphate dihydrate, sucrose, water for injections). The most frequent **adverse reactions** in participants 16 years of age and older were injection site pain (> 80%), fatigue (> 60%), headache (> 50%), myalgia and chills (> 30%), arthralgia (> 20%), pyrexia and injection site swelling (> 10%) and were usually mild or moderate in intensity and resolved within a few days after vaccination. A slightly lower frequency of reactogenicity events was associated with greater age. Events of anaphylaxis have been reported. Appropriate medical treatment and supervision should always be readily available in case of an anaphylactic reaction following the administration of the vaccine. Close observation for at least 15 minutes is recommended following vaccination. A second dose of the vaccine should not be given to those who have experienced anaphylaxis to the first dose of Comirnaty.

Herausforderung: Aufbewahrung bei 90 °C to -60 °C

Vaccine should be **stored**. in a freezer at -90 °C to -60 °C. Vials removed from frozen storage (< -60 °C) may be at room temperature (< 25 °C) for up to 3 minutes to remove vials or for transfer between ultra-low-temperature environments. Once a vial is removed from the vial tray, it should be thawed for use. After vial trays are returned to frozen storage following room temperature exposure, they must remain in frozen storage for at least 2 hours before they can be removed again. Detailed special precautions for disposal and other handling should be found in product information document [63]

Phase 1 / 2 mehrstufiges Studiendesign

Phase 1/ 2 (Deutschland)

November 2022

A **phase 1/2**, randomized, placebo-controlled, triple-blind, dose-finding, and vaccine candidate-selection study in healthy adults in the US as well as in Germany [64] (**NCT04368728**/EudraCT 2020-001038-36). The study evaluates the safety, tolerability, immunogenicity, and potential efficacy of up to 4 different SARS-CoV-2 RNA vaccine candidates against (COVID-19 BNT162a1, BNT162b1, BNT162b2, and BNT162c2): as a 2-dose or single-dose schedule; at up to 3 different dose levels; in 3 age groups (18 to 55 years of age, 65 to 85 years of age, and 18 to 85 years of age. The study consists of 3 stages: Stage 1: to identify preferred vaccine candidate(s), dose level(s), number of doses, and schedule of administration (with the first 15 participants at each dose level of each vaccine candidate comprising a sentinel cohort); Stage 2: an expanded-cohort stage; and Stage 3; a final candidate/dose large-scale stage. Study NCT04380701 is located in Germany.

Phase 2/3 RCT läuft derzeit

Phase 2/3 RCT is ongoing (**NCT04368728**/EudraCT 2020-002641-42) with aim to describe the safety, tolerability, immunogenicity and efficacy of RNA vaccine candidate against COVID-19 in healthy adults (Argentina, Brazil, South Africa, Turkey, US). The candidate selected for evaluation in Phase 2/3 is BNT162b2 (mid-dose). Estimated number of participants is 43998, and completion study date December 2022 [9].

2.4 Janssen Pharmaceutical/ Johnson & Johnson

About the vaccine

Ad.26.COV2.S

The Janssen Pharmaceutical Companies of Johnson & Johnson developed the investigational vaccine (also known as Ad.26.COV2.S), a recombinant vector vaccine that uses a human adenovirus to express the SARS-CoV-2 spike protein in cells.

Conditional marketing authorisation in EU

vorläufige Zulassung in EU am 11. März 2021

On 11 March 2021, the **European Commission** (EC) has given the **conditional marketing authorisation** for the **COVID-19 Vaccine Janssen (vaccine efficacy 67%),** following evaluation by EMA.

≥ 18 Jahre, ein-malige Impfung

Nebenwirkungen

COVID-19 Vaccine Janssen is **indicated** for active immunisation to prevent COVID-19 caused by SARS-CoV-2 in individuals 18 years of age and older, administered as a single-dose of 0.5 mL by intramuscular injection only. Only **contraindication** is hypersensitivity to the active substance or to any of the excipients. Events of anaphylaxis have been reported. Appropriate medical treatment and supervision should always be readily available in case of an anaphylactic reaction following the administration of the vaccine. Close observation for at least 15 minutes is recommended following vaccination. The most common local **adverse reactions** reported was injection site pain (48.6%). The most common systemic adverse reactions were headache (38.9%), fatigue (38.2%), myalgia (33.2%) and nausea (14.2%). Pyrexia (defined as body temperature ≥38.0°C) was observed in 9% of participants. Most adverse reactions occurred within 1–2 days following vaccination and were mild to moderate in severity and of short duration (1–2 days). Reactogenicity was generally milder and reported less frequently in older adults (763 adults ≥65 years old). **The duration of protection** afforded by the vaccine is unknown as it is still being determined by ongoing clinical trials. **Storage**: Shelf life is 2 years when stored at -25°C to -15°C. Once removed from the freezer, the unopened vaccine may be stored refrigerated at 2°C to 8°C, protected from light, for a single period of up to 3 months, not exceeding the printed expiry date [65, 66].

Phase 3 RCT läuft noch: 60.000 Teilnehmer*innen

Janssen Pharmaceutical phase 3, randomised controlled trial (NCT04505722) is ongoing in the United States, South Africa and Latin American countries, to demonstrate the efficacy of Ad26.COV2.S in the prevention of molecularly confirmed moderate to severe/critical COVID-19, compared to placebo, in SARS-CoV-2 adult participants. Estimated enrollment is 60,000 participants, with study completion day in March 2023.

2.5 Novavax

About the vaccine

CEPI
Matrix-M™

The Novavax COVID-19 vaccine being developed by Novavax and co-sponsored by CEPI [67] is a recombinant protein nanoparticle technology platform that is to generate antigens derived from the coronavirus spike (S) protein [68]. Matrix-M™ is Novavax patented saponin-based adjuvant that has the potential to boost the immune system by stimulating the entry of

antigen-presenting cells into the injection site and enhancing antigen presentation in local lymph nodes, boosting immune responses [69, 70].

Estimated timeline for approval

The **phase 1/2**, randomized, placebo-controled, triple-blind, parallel assignment clinical trial (NCT04368988) in 131 healthy adults aims to evaluate the immunogenicity and safety of SARS-CoV-2 rS nanoparticle vaccine with or without Matrix-M adjuvant in healthy participants ≥ 18 to 59 years of age [71-74]. This RCT will be conducted from May 15, 2020 to July 31, 2021. Estimated Primary Completion Date is December 31, 2020.

Phase 1:
131 gesunde Erwachsene

Juli 2021

A **phase 2b** RCT trial (NCT04533399) aims to evaluate the effectiveness and safety in South Africans adults; 2904 participants are planned to enrolled, with estimated primary completion date in November 2021 [74].

Phase 2b RCT
2.904 Südafrika
bis 2021

A **phase 3** RCT (EUdraCT 2020-004123-16) is ongoing, in healthy adults in the UK. Main aim is to demonstrate the efficacy of SARS-CoV-2 rS with Matrix-M1 adjuvant in the prevention of virologically confirmed (by polymerase chain reaction [PCR]) to SARS-CoV-2, symptomatic COVID-19, when given as a 2-dose vaccination regimen, as compared to placebo, in serologically negative (to SARS-CoV-2) adult participants. 9000 participants are planned to enrolled.

Phase 3
9.000 Teilnehmer*innen
in UK

Results of publications

A results from above mentioned randomized, placebo-controlled, **phase 1/2 trial** to evaluate the safety and immunogenicity of the rSARS-CoV-2 vaccine (in 5-µg and 25-µg doses, with or without Matrix-M1 adjuvant, and with observers unaware of trial-group assignments) in 131 healthy adults were published [12]. In phase 1, vaccination comprised two intramuscular injections, 21 days apart. After randomization, 83 participants were assigned to receive the vaccine with adjuvant and 25 without adjuvant, and 23 participants were assigned to receive placebo. No serious adverse events were noted. Unsolicited adverse events were mild in most participants; there were no severe adverse events. The two-dose 5-µg adjuvanted regimen induced geometric mean anti-spike IgG (63,160 ELISA units) and neutralization (3906) responses that exceeded geometric mean responses in convalescent serum from mostly symptomatic Covid-19 patients (8344 and 983, respectively).

Publikation der Phase 1/2

keine schwerwiegenden NW beobachtet

Formica et al. 2021 [13] published, as preprint, results from **phase 2 component** of above mentioned RCT (NCT04368988): participants were randomly assigned to receive either one or two intramuscular doses of 5-µg or 25-µg NVX-CoV2373 or placebo, 21 days apart. Approximately 250 participants each were assigned to one of four vaccine groups or placebo. Of these, approximately 45% were older participants. Reactogenicity was predominantly mild to moderate in severity and of short duration (median <3 days) after first and second vaccination with NVX-CoV2373, with higher frequencies and intensity after second vaccination and with the higher dose, and occurred less frequently and was of lower intensity in older participants. The two-dose regimen of 5-µg NVX-CoV2373 induced robust geometric mean titer (GMT) IgG anti-spike protein (65,019 and 28,137 EU/mL) and wild-type virus neutralizing antibody (2201 and 981 titers) responses in younger and older participants, respectively, with seroconversion rates of 100% in both age groups.

Phase 2 RCT Publikation
250 Teilnehmer*innen
in 4 Gruppen

On January 28, 2021 Novavax, Inc. **announced** that NVX-CoV2373, its protein-based COVID-19 vaccine candidate, met the primary endpoint, with a vaccine efficacy of **89.3%**, in its **phase 3** clinical trial conducted in the United Kingdom. The study assessed efficacy during a period with high transmission and with a **new UK variant strain** of the virus emerging and circulating widely. It was conducted in partnership with the UK Government's Vaccines Taskforce. Novavax also announced successful results of its **phase 2b** study conducted in South Africa in which approximately 90% of COVID-19 cases attributed to **South Africa** escape **variant**: **60% efficacy** for the prevention of mild, moderate and severe COVID-19 disease was observed [75].

Phase 3 RCT veröffentlicht: UK

89,3% Wirksamkeit (auch bei hohem Anteil von UK-Mutation)

60% Wirksamkeit bei SA-Mutation

Shinde et al. 2021 [14] published as preprint **preliminary results** from phase **2a/b** RCT in **South Africa**: a total of 4387 participants were randomized and dosed at least once, 2199 with NVX-CoV2373 and 2188 with placebo. Vaccine efficacy was 49.4% (95% confidence interval [CI]: 6.1 to 72.8). Efficacy in HIV-negative participants was 60.1% (95% CI: 19.9 to 80.1), and did not differ by baseline serostatus. Of the primary endpoint cases with available whole genome sequencing, 38 (92.7%) of 41 were the B.1.351 variant. Post-hoc vaccine efficacy against B.1.351 was 51.0% (95% CI: - 0.6 to 76.2) in HIV-negative participants.

Phase 2a/b RCT 4.387 Teilnehmer*innen

2.6 CureVac

About the vaccine

The vaccine candidate CVnCoV, developed by CureVac, is a protamine-complexed mRNA-based vaccine expressing undisclosed SARS-CoV-2 protein(s). Each CureVac product is a tailored molecular creation that contains 5' and 3' untranslated regions and the open reading frame to make sure translation of the messenger RNA (mRNA) sequence results in appropriate levels of proteins in the body. This means that CureVac's technology uses mRNA as a data carrier in order to train the human body to produce ideal levels of proteins. Thereby the immune system is stimulated and can respond to antigens [76, 77].

mRNA

CureVac and Bayer joint forces in January 2021 on COVID-19 vaccine candidate CVnCoV to ramp up the production and distribution of vaccine. Vaccine remains stable and within defined specifications for at least three months when stored at a standard refrigerator temperature of +5°C (+41°F) and for up to 24 hours as ready-to-use vaccine when stored at room temperature, https://www.curevac.com/en/covid-19/.

Jänner 2021: CureVac kooperiert mit Bayer

Estimated timeline for approval

Phase 1 (NCT04449276) study aims to evaluate the safety and reactogenicity profile after 1 and 2 dose administrations of CVnCoV at different dose levels. Is is funded by Coalition for Epidemic Preparedness Innovations (CEPI), and located in Belgium and Germany. More then 250 healthy participants are enrolled in the trial. Preliminary results reported as preprint in November 2020 strongly supported the decision to advance a 12μg dose in the pivotal phase 2b/3 study [26], https://www.curevac.com/en/covid-19/.

Phase 1: Beginn klinische Studie: Sommer 2020

Phase 2

Phase 2, RCT (NCT04515147) initiated in September 2020 aims to evaluate the safety and reactogenicity profile after 1 and 2 dose administrations of investigational SARS-CoV-2 mRNA vaccine (CVnCoV) at different dose levels and to evaluate the humoral immune response after 1 and 2 dose administrations of CVnCoV. 691 participants are planned to be enroll in the trial, with estimated study completion date in November 2021 [74].

Phase 2/3

Pivotal **phase 2b/3** study (NCT04652102/EUdraCT 2020-00399822), initiated in December 2020, assesses a 12μg dose of CVnCoV in two parts: an initial phase 2b trial which is expected to seamlessly merge into a phase 3 efficacy trial. Both the phase 2b and phase 3 trials are randomized, observer-blind, placebo-controlled studies in adults over 18 years of age or older. While the objective of the phase 2b study is to further characterize the safety, reactogenicity and immunogenicity of CVnCoV, the phase 3 assesses CVnCoV efficacy. Subjects will be enrolled at multiple sites and vaccinations follow a two-dose schedule on day 1 and day 29 of either CVnCoV or a placebo. In total, more than 35,000 participants will be included in the phase 2b/3 HERALD study at multiple sites in Europe and Latin America, https://www.curevac.com/en/covid-19/.

Phase 3

A **phase 3** RCT (NCT04674189) aims to evaluate the safety and immunogeneity of CVnCoV vaccine in adult health care workers in Germany. Estimated enrollments is 2520 participants, with estimated primary completion date in June 2021. [74]

Results of publications

Phase 1: akzeptable Sicherheitsdaten

Preliminary results related to **phase 1** (NCT04449276) reported as **preprint** in November 2020 showed that two doses of CVnCoV ranging from 2 µg to 12 µg per dose, administered 28 days apart were safe. No vaccine-related serious adverse events were reported. There were dose-dependent increases in frequency and severity of solicited systemic adverse events, and to a lesser extent of local reactions, but the majority were mild or moderate and transient in duration. Median titers measured in assays two weeks after the second 12 µg dose were comparable to the median titers observed in convalescent sera from COVID-19 patients. Seroconversion (defined as a 4-fold increase over baseline titer) of virus neutralizing antibodies two weeks after the second vaccination occurred in all participants who received 12 µg doses [26].

2.7 Sanofi and GSK

About the vaccine

Protein subunit

In April 2020, Sanofi and GSK agreed to develop an adjuvanted vaccine for COVID-19, using innovative technology from both companies. Sanofi through its S-protein COVID-19 antigen, based on recombinant DNA technology (this technology has produced an exact genetic match to proteins found on the surface of the virus, and the DNA sequence encoding this antigen has been combined into the DNA of the baculovirus expression platform, the basis of Sanofi's licensed recombinant influenza product in the US). GSK through its proven pandemic adjuvant technology which can be of particular importance in a pandemic situation since it may reduce the amount of vaccine protein required per dose, allowing more vaccine doses to be

produced and therefore contributing to protect more people. Development of the recombinant-based COVID-19 vaccine candidate is being supported through funding and a collaboration with the Biomedical Advanced Research and Development Authority (BARDA), part of the office of the Assistant Secretary for Preparedness and Response at the U.S. Department of Health and Human Services, https://www.sanofi.com/en/media-room/press-releases/2020/2020-04-14-13-00-00. Vaccine could be kept in standard refrigerators, making it easier to distribute.

Estimated timeline for approval

Phase 1/2

On December 11, 2020 Sanofi and GSK announced a delay in their adjuvanted recombinant protein-based COVID-19 vaccine program to improve immune response in older adults. https://www.sanofi.com/en/media-room/press-releases/2020/2020-12-11-07-00-00.

Phase 1/2 study

Zwischenauswertung

Antikörperbildung am besten bei 18-49 J,

weniger bei ≥ 50 J oder gar bei ≥ 60 J

The interim RCT, **phase 1/2** results (NCT04537208, as preprint) showed a level of neutralising antibody titers after two doses comparable to sera from patients who recovered from COVID-19, a balanced cellular response in adults aged 18 to 49 years, but insufficient neutralising antibody titers in adults over the age of 50. The candidate showed transient but higher than expected levels of reactogenicity likely due to the suboptimal antigen formulation, with no serious adverse events related to the vaccine candidate. The most favorable results were observed in the group which tested the highest antigen concentration, combined with the GSK adjuvant, showing neutralisation titers in 88% of participants. Seroconversion was observed in 89.6% of the 18 to 49 age group; 85% in the >50 age group; and 62.5% in the >60 age group [27].

Phase 2b and phase 3 studies

Phase 2b in Planung
Phase 3: Q2 2021

Zulassung ev. Q4 2021

The Companies initiate a **phase 2b** study with an improved antigen formulation in February 2021. The study will include a proposed comparison with an authorized COVID-19 vaccine. If data are positive, a global **phase 3** study could start in Q2 2021. Positive results from this study would lead to regulatory submissions in the second half of 2021, hence **delaying the vaccine's potential availability from mid-2021 to Q4 2021,**
https://www.sanofi.com/en/media-room/press-releases/2020/2020-12-11-07-00-00.

2.8 Valneva

About the vaccine

inaktivierte SARS-CoV-2-Viren

Valneva vaccine candidate VLA2001 consists of inactivated whole virus particles of SARS-CoV-2 with high S-protein density, in combination with two adjuvants, alum and CpG 1018. This adjuvant combination has consistently induced higher antibody levels in preclinical experiments than alum-only formulations and shown a shift of the immune response towards Th1. VLA2001 is produced on Valneva's established Vero-cell platform, leveraging the manufacturing technology for Valneva's licensed Japanese

encephalitis vaccine, IXIARO®. The process, which has already been upscaled to final industrial scale, includes inactivation with BPL to preserve the native structure of the S-protein.

VLA2001 is expected to conform with standard cold chain requirements (2-8° C).

Estimated timeline for approval

Valneva initiated **phase 1/2** clinical study in December 2020; randomised, double blind trial evaluating the safety and immunogenicity for three dose levels in approximately 150 healthy adults. The primary endpoint read-out will be two weeks after completion of the two-dose primary immunization (day 0, 21). Subject to analysis of this data, additional trials are expected to commence immediately thereafter. A total of 150 healthy adults aged 18 to 55 years have been recruited. Initial results are expected in April 2021, https://valneva.com/press-release/valneva-commences-manufacturing-of-its-inactivated-adjuvanted-covid-19-vaccine-completes-phase-1-2-study-recruitment/

Phase 1/ 2 RCT began im Dez 2020
150 Teilnehmer*innen

Ergebnisse im April 2021

On 6 April 2021, Valneva announced results from above mentioned RCT, suggested the vaccine is immunogenic, with more than 90% of all study participants developing significant levels of antibodies to the SARS-CoV-2 virus spike protein across three dose groups tested. In the high dose group, after two doses, antibody titres were at or above levels for a panel of convalescent sera, 2021 https://valneva.com/press-release/valneva-reports-positive-phase-1-2-data-for-its-inactivated-adjuvanted-covid-19-vaccine-candidate-vla2001/.

Presseaussendung: 90% der Impfstudien-Teilnehmer*innen entwickelten Antikörper

The Company currently plans to include more than 4,000 participants in additional trials, which it believes could support an initial regulatory approval as soon as the fourth quarter of 2021.

Planung von RCT mit 4.000 Teilnehme*innen

3 Results: Therapeutics

Current therapeutic management of patients with COVID-19 (outpatients and hospitalised patients): Summary

derzeitige Therapien im Management von Covid-19 Patient*innen

Dexamethasone (and other corticosteroids)

zugelassen:

Dexamethasone (und andere Korikosteroide)

In **EU, dexamethasone use** is endorsed by **EMA** following referral procedure: it is **indicated** in **adults and adolescents (from 12 years of age and weighing at least 40 kg) who require supplemental oxygen therapy.** In all cases, the recommended dose in adults and adolescents is **6 milligrams once a day for up to 10 days.**

von WHO & US COVID-19 Treatment Guidelines Panel empfohlen

In current **WHO living guidance** the WHO panel made two recommendations: a **strong recommendation** (based on moderate certainty evidence) **for systemic** (i.e. intravenous or oral) **corticosteroid therapy** (e.g. 6 mg of dexamethasone orally or intravenously daily or 50 mg of hydrocortisone intravenously every 8 hours) for 7 to 10 days in **patients with severe and critical COVID-19**, and a **conditional recommendation** (based on low certainty evidence) **not to use corticosteroid therapy in patients with non-severe COVID-19.**

The **US COVID-19 Treatment Guidelines Panel recommends using dexamethasone** (at a dose of 6 mg per day for up to 10 days) in patients with COVID-19 who are mechanically ventilated **(AI)** and in patients with COVID-19 who require supplemental oxygen but who are not mechanically ventilated **(BI).** The Panel **recommends against** using dexamethasone in patients with COVID-19 who do not require supplemental oxygen **(AI).** If dexamethasone is not available, the Panel **recommends using** alternative glucocorticoids such as **prednisone, methylprednisolone, or hydrocortisone (AIII).** *See also remdesivir and tocilizumab below.*

Daily regimen of dexamethasone 6 mg once daily is equivalent to 160 mg of hydrocortisone, 40 mg of prednisone, and 32 mg of methylprednisolone.

Remdesivir (Veklury)

zugelassen:
Remdesivir (Veklury)

Remdesivir (Veklury) is an antiviral medicine for systemic use which received a **conditional marketing authorisation** in **EU.** It is **indicated** for the treatment of coronavirus disease 2019 (**COVID-19**) in **adults and adolescents** (aged 12 years and older with body weight at least 40 kg) with **pneumonia requiring supplemental oxygen.**

von WHO nicht empfohlen

von US COVID-19 Treatment Guidelines Panel nur empfohlen für Patient*innen,

die zusätzlich Sauerstoff benötigen, nicht aber für jene, die bereits künstlich beatmet werden

The **U.S. Food and Drug Administration approved** remdesivir for use in **adult and pediatric patients 12 years of age and older** and weighing at least 40 kilograms (about 88 pounds) for the treatment of **COVID-19 requiring hospitalisation.**

Current WHO living guidance on remdesivir for COVID-19 has a **conditional recommendation against the use of remdesivir in hospitalised patients with COVID-19, regardless of disease severity.**

The US COVID-19 Treatment Guidelines Panel issued new recommendations on remdesivir treatment for patients with COVID-19: It is **recommended for use in hospitalised patients who require supplemental oxygen**. However, it is **not routinely recommended for patients who require mechanical ventilation** due to the lack of data showing benefit at this advanced stage of the disease.

For Hospitalized Patients With COVID-19 Who Require Supplemental Oxygen but Who Do Not Require Oxygen Delivery Through a High-Flow Device, Noninvasive Ventilation, Invasive Mechanical Ventilation, or Extracorporeal Membrane Oxygenation: **Remdesivir** (e.g., for patients who require minimal supplemental oxygen) **(BIIa)**; **Dexamethasone plus remdesivir** (e.g., for patients who require increasing amounts of oxygen) **(BIII)**;

For Hospitalized Patients With COVID-19 Who Require Delivery of Oxygen Through a High-Flow Device or Noninvasive Ventilation but Not Invasive Mechanical Ventilation or Extracorporeal Membrane Oxygenation: **Dexamethasone** alone **(AI)**; **or a** combination of **dexamethasone plus remdesivir (BIII)**.

Baricitinib in combination with remdesivir

The **FDA** recently issued an **emergency use authorization (EUA)** for the Janus kinase inhibitor **baricitinib** to be used **in combination with remdesivir** in patients with **COVID-19** who **require oxygen or ventilatory support.**

zugelassen nur in USA (EUA): Baricitinib als Kombinationstherapie mit Remdesivir

The **US COVID-19 Treatment Guidelines Panel** stated that there are **insufficient data** to recommend either **for or against** baricitinib in combination with remdesivir therapy in **hospitalised patients** with COVID-19 disease, in cases where corticosteroids can be used instead. In the rare circumstances where corticosteroids cannot be used, the Panel recommends using baricitinib in combination with remdesivir for the treatment of COVID-19 in hospitalised, nonintubated patients who require oxygen supplementation **(BIIa).** The Panel **recommends against** the use of baricitinib in the absence of remdesivir, except in a clinical trial **(AIII)**.

US COVID-19 Treatment Guidelines Panel: insuffiziente Datenlage für Empfehlung

Casirivimab and imdevimab (REGN-COV2)

The **U.S. Food and Drug Administration** issued an **emergency use authorization (EUA)** for casirivimab and imdevimab (REGN-COV2) to be administered together for the **treatment** of **mild to moderate COVID-19** in **adults and pediatric patients** (12 years of age or older weighing at least 40 kilograms [about 88 pounds]) with positive results of direct SARS-CoV-2 viral testing and who are **at high risk for progressing to severe COVID-19.**

zugelassen nur in USA (EUA): Casirivimab and imdevimab (REGN-COV2)

On **February 26, 2021 EMA** stated that the CHMP has completed its review to provide a **harmonised scientific opinion** at EU level to support national decision making on the possible use of the antibodies **before a formal authorisation is issued**. The Agency concluded that the combination (REGN-COV2) **can be used** for the treatment of **confirmed COVID-19 in patients who do not require supplemental oxygen and who are at high risk of progressing to severe COVID-19**.

Feb - EMA rolling review: nur für bestätigte Covid-19, die keine Beatmung brauchen, aber Hochrisiko für Fortschreiten zu schwerer Erkrankung

The **US COVID-19 Treatment Guidelines Panel recommends** using one of the following combination anti-SARS-CoV-2 monoclonal antibodies to treat outpatients with mild to moderate COVID-19 who are at high risk of clinical progression, as defined by the Emergency Use Authorization (EUA) criteria (listed in alphabetical order): **Bamlanivimab 700 mg plus etesevimab 1,400 mg (AIIa); or Casirivimab 1,200 mg plus imdevimab 1,200 mg (AIIa).**

US COVID-19 Treatment Guidelines Panel: Empfehlung FÜR Verwendung von Kombinationstherapien bei mild/ moderater Erkr.

There are currently **no comparative data** to determine whether there are differences in clinical efficacy or safety between **casirivimab plus imdevimab and bamlanivimab.**

keine Daten zu Kombinationstherapien

The Panel **recommends against** the use of **anti-SARS-CoV-2 monoclonal antibodies** for patients who are hospitalized because of COVID-19, except in a clinical trial (AIIa). However, their use should be considered for persons with mild to moderate COVID-19 who are hospitalized for a reason other than COVID-19 but who otherwise meet the EUA criteria.

Empfehlung GEGEN Therapie bei hospitalisierten Pts.

Bamlanivimab monotherapy or in combination with etesevimab

The **U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA)** for the investigational monoclonal antibody therapy bamlanivimab (previously LY-CoV555) for the treatment of **mild-to-moderate COVID-19** in adult and pediatric patients. Bamlanivimab is authorized for patients with positive results of direct SARS-CoV-2 viral testing who are **12 years of age and older** weighing at least 40 kilograms (about 88 pounds), and who are **at high risk for progressing to severe COVID-19 and/or hospitalisation.**

zugelassen nur in USA (EUA): Bamlanivimab

On February 9, 2021 the **FDA** issued an **EUA** for **bamlanivimab and etesevimab administered together** for the treatment of **mild to moderate COVID-19** in adults and pediatric patients (12 years of age or older weighing at least 40 kilograms [about 88 pounds]) who test positive for SARS-CoV-2 and who are **at high risk for progressing to severe COVID-19**.

Feb 2021: zugelassen in USA (EUA) als Kombinationstherapie bamlanivimab + etesevimab

On March 5, 2021 **EMA** stated that the CHMP has completed its review started in February 2021, to provide a **harmonised scientific opinion** at EU level to support national decision making on the possible use of the antibodies **before a formal authorisation is issued**. The Agency concluded that **bamlanivimab monotherapy** and **bamlanivimab and etesevimab combination** can be used together to treat confirmed COVID-19 in patients who **do not require supplemental oxygen and who are at high risk of their COVID-19 disease becoming severe.**

März - EMA rolling review: nur für bestätigte Covid-19, die keine Beatmung brauchen, aber Hochrisiko für Fortschreiten zu schwerer Erkrankung

The **US COVID-19 Treatment Guidelines Panel recommends** using one of the following combination anti-SARS-CoV-2 monoclonal antibodies to treat outpatients with mild to moderate COVID-19 who are at high risk of clinical progression, as defined by the Emergency Use Authorization (EUA) criteria (listed in alphabetical order): **Bamlanivimab 700 mg plus etesevimab 1,400 mg (AIIa); or Casirivimab 1,200 mg plus imdevimab 1,200 mg (AIIa).**

US COVID-19 Treatment Guidelines Panel: Empfehlung FÜR Verwendung von Kombinationstherapien bei mild/ moderater Erkr.

Because clinical outcome data are limited and there are concerns regarding decreased susceptibility of variants, the Panel **recommends against** the use of **bamlanivimab monotherapy (AIII).** If combination products are not available, the use of bamlanivimab monotherapy can be considered for people who meet the EUA criteria on a case-by-case basis.

Empfehlung GEGEN Monotherapie

The Panel **recommends against** the use of **anti-SARS-CoV-2 monoclonal antibodies** for patients who are hospitalized because of COVID-19, except in a clinical trial **(AIIa)**. However, their use should be considered for persons with mild to moderate COVID-19 who are hospitalized for a reason other than COVID-19 but who otherwise meet the EUA criteria.

Empfehlung GEGEN Therapie bei hospitalisierten Pts.

Regdanvimab (Regkirona)

On 26 March 2021 **EMA** announced that CHMP has completed a review of Celltrion's monoclonal antibody regdanvimab (CT-P59) to **support national authorities** who may decide on the use of this medicine for COVID-19 prior to authorisation. EMA **concluded** that regdanvimab can be used for the **treatment of confirmed COVID-19 in adult patients that do not require supplemental oxygen for COVID-19 and who are at high risk of progressing to severe COVID19**.

März - EMA rolling review: nur für bestätigte Covid-19, die keine Beatmung brauchen, aber Hochrisiko für Fortschreiten zu schwerer Erkrankung

Convalescent plasma

On **February 4 2021**, **FDA** announced that former **EUA** is **being revised** to authorize **only the use of high titer COVID-19 convalescent plasma**, for the treatment of **hospitalized patients** with COVID-19, **early in the disease course** and those hospitalized with **impaired humoral immunity**.

FDA-Revision der Zulassung von Reconvalezentenplasma: nur mit hohem Titer

Tocilizumab

On February 11, 2021 **RECOVERY Collaborative Group** published as preprint **preliminary results** from the **RECOVERY trial** related to tocilizumab arm: tocilizumab improved survival and other clinical outcomes in severe and critical COVID-19 patients. These benefits were seen regardless of the level of respiratory support and were additional to the benefits of systemic corticosteroids.

RECOVERY Ergebnisse: bessere Ergebnisse bei schwerer/ kritischer Erkrankung unter tocilizumab

The **US COVID-19 Treatment Guidelines Panel** recommends the use of **tocilizumab** (single intravenous dose of 8 mg/kg of actual body weight, up to 800 mg) **in combination with dexamethasone** (6 mg daily for up to 10 days) in certain hospitalized patients who are exhibiting rapid respiratory decompensation due to COVID-19. The patients included in this population are: Recently hospitalized patients who have been admitted to the intensive care unit (ICU) within the prior 24 hours and who require invasive mechanical ventilation, noninvasive mechanical ventilation (NIV), or high-flow nasal canula (HFNC) oxygen (>0.4 FiO_2/30 L/min of oxygen flow) **(BIIa)**; *or* Recently hospitalized patients (not in the ICU) with rapidly increasing oxygen needs who require NIV or HFNC and have significantly increased markers of inflammation **(BIIa)** (**Note**: The RECOVERY trial inclusion criterion for inflammation was C-reactive protein [CRP] ≥75 mg/L).

US COVID-19 Treatment Guidelines Panel: Empfehlung in Kombinaion mit Dexamethasone in einigen Patientengruppen,

ICU, beatmet, etc.

Lopinavir + ritonavir, chloroquine and hydroxychloroquine

Lopinavir + ritonavir, chloroquine and hydroxychloroquine are not effective in treating **COVID-19 patients.**

Lopinavir + ritonavir, chloroquine and hydroxychloroquine: Nachweis für keine Wirksamkeit

Other pharmaceuticals listed in this document

Related to other pharmaceuticals listed in this document the **current evidence** is **uncertain or very uncertain** about their effect on different clinical outcomes in **COVID-19 patients**. Further RCTs are currently ongoing.

EMA is providing guidance to assist developers of potential COVID-19 medicines, to prepare for eventual applications for marketing authorisation. This includes scientific advice, as well as informal consultation with the COVID-19 EMA pandemic Task Force (COVID-ETF). The outcome of any consultation or advice from EMA is not binding on developers.

EMA scientific advice für viele unterschiedliche Medikamente

COVID-19 medicines that have received EMA advice can be found in Table 3-1 below, https://www.ema.europa.eu/en/human-regulatory/overview/public-health-threats/coronavirus-disease-covid-19/treatments-vaccines/treatments-covid-19/covid-19-treatments-research-development.

Table 3-1: COVID-19 medicines that have received EMA advice

Product	Developer	Therapeutic class/drug type	Development stage at time of guidance
VIR-7831, VIR-7832	Vir Biotechnology/GSK	Antiviral (monoclonal antibody)	Clinical phase
UNI911	Union Therapeutics	Antiviral	Clinical phase
Tocilizumab	Roche	Immunomodulator	Clinical phase
SNG-001	Synargein	Immunomodulator	Clinical phase
Siltuximab	EUSApharma	Immunomodulator	Clinical phase
Sarilumab	Sanofi Aventis	Immunomodulator	Clinical phase
Remdesivir	Gilead	Antiviral	Clinical phase
RBT-9	Renibus Therapeutics Inc	Antiviral	Clinical phase
Ravulizumab	Alexion	Other therapeutics	Clinical phase
Otilimab	GSK	Immunomodulator	Clinical phase
Meplazumab	Jiangsu Pacific Meinuoke Biophar.	Antiviral (mAb)	Clinical phase
Mavrilimumab	Kiniksa Pharmaceuticals	Immunomodulator	Clinical phase
Gimsilumab	Roivant	Immunomodulator	Clinical phase
Favipiravir	Glenmark Pharmaceuticals Ltd	Antiviral	Clinical phase
Emapalumab and anakinra	Swedish Orphan Biovitrum AB	Immunomodulator	Clinical phase
Eculizumab	Alexion	Immunomodulator	Clinical phase
Danoprevir	Ascletis Pharmaceuticals Co Ltd	Antiviral	Clinical phase
Copper chloride	ACOM srl	Antiviral	Clinical phase
Chloroquine and hydroxychloroquine cyclops DPI	PureIMS	Other therapeutics	Clinical phase
Chloroquine	Oxford University	Other therapeutics	Clinical phase
CD24Fc	Oncoimmune Inc	Immunomodulator	Clinical phase
Baricitinib	Eli Lilly	Immunomodulator	Clinical phase
Apremilast	Amgen Europe BV	Immunomodulator	Clinical phase
APN01	Apeiron Biologics	Immunomodulator	Clinical phase
Anti-SARS-CoV-2 polyclonal hyperimmune immunoglobulin	Alliance hyperimmune project (Biotest AG, Bio Products Laboratory, LFB, Octapharma, CSL Behring and Takeda)	Antiviral	Clinical phase
Acalabrutinib	Acerta Pharma BV	Immunomodulator	Clinical phase
ABBV-47D11	AbbVie	Antiviral	Clinical phase
AT-527	Roche	Antiviral	Clinical phase
Aviptadil	Relief Therapeutics Holding S.A	Other therapeutics	Clinical Phase
BI 764198	Boehringer Ingelheim International	Other therapeutic	Clinical phase
Emiplacel	Biopharma Excellence GmbH	Other therapeutic	Clinical Phase
Itolizumab	Biocon Biologics Limited	Immunomodulator (monoclonal antibody)	Clinical phase
SCTA01	Sinocelltech Ltd.	Antiviral (monoclonal antibody)	Clinical phase
Colchicine	Pharmascience Inc. / Montreal Healt	Immunomodulator	Clinical phase
IgM enriched human immune globulin (Trimodulin) (BT588)	Biotest AG	Antiviral	Clinical phase

In this document we present information for some therapies in development.

Table 3 -2: Most advanced therapeutics in the R&D pipeline

Drug	Mechanism of operation	Approval Status Withdrawn, suspended or terminated
Remdesivir (Veklury®)	Antiviral agent	**EMA: Conditional marketing authorisation granted** **FDA: Marketing authorisation granted** 2 RCTs (suspended and terminated)
Favipiravir (Avigan, T-705)	Antiviral agent	No withdrawn, suspended or terminated studies found
Darunavir (Prezista®)	Antiviral agent	No withdrawn, suspended or terminated studies found
Camostat Mesilate (Foipan®)	Antiviral cell-entry inhibitor	1 RCT-withdrawn, no suspended or terminated studies found
APN01 (rhACE2)	Antiviral cell-entry inhibitor	1 RCT withdrawn
Tocilizumab (RoActemra®)	Monoclonal antibody	1 RCT withdrawn, 4 RCTs terminated
Sarilumab (Kevzara®)	Monoclonal antibody	1 RCT suspended, 1 RCTs terminated
Interferon beta 1a (SNG001) **and 1b**	Interferon	1 RCT suspended
Convalescent Plasma	Convalescent Plasma	**FDA revised Emergency Use Authorisation (EUA): only the use of high titer COVID-19 convalescent plasma**, for **hospitalised patients**, **early in the disease course,** with **impaired humoral immunity)** 1 RCT terminated, 1 RCT withdrawn
Plasma derived medicinal products: REGN-COV2; LY-CoV555 (bamlanivimab); LY-CoV016 (etesevimab); AZD7442; VIR-7831; regdanvimab	Neutralizing monoclonal antibodies	**FDA Emergency Use Authorisation (EUA): REGN-COV2 (casirivimab+imdevimab)** **EMA: Use endorsed after Article 5(3) review** **FDA Emergency Use Authorisation (EUA): Bamlanivimab** **EMA: Use endorsed after Article 5(3) review** **FDA Emergency Use Authorisation (EUA): Bamlanivimab+etesevimab** **EMA: Use endorsed after Article 5(3) review** No withdrawn, suspended or terminated studies found
Solnatide	Synthetic peptide	No withdrawn, suspended or terminated studies found
Umifenovir (Arbidol®)	Antiviral agent	No withdrawn, suspended or terminated studies found
Dexamethasone and other corticosteroids **Inhaled corticosteroids: Budesonide**	Glucocorticoid	**EMA: Dexamethasone use endorsed after Article 5(3) review** 2 RCTs terminated, 1 RCT suspended, 1 RCT withdrawn 1 RCT terminated
Anakinra (Kyneret®)	Interleukin 1 receptor antagonist	1 RCT suspended, 2-RCT terminated
Colchicine	An alkaloid, with anti-gout and anti-inflammatory activities	1 RCT withdrawn, no suspended or terminated studies found
Nafamostat (Futhan©)	Trypsin-like serine protease inhibitor	No withdrawn, suspended or terminated studies found
Gimsilumab	Human monoclonal antibody	No withdrawn, suspended or terminated studies found
Canakinumab	Human monoclonal antibody	No withdrawn, suspended or terminated studies found
Lenzilumab	Recombinant monoclonal antibody	No withdrawn, suspended or terminated studies found
Vitamin D	Vitamin	No withdrawn, suspended or terminated studies found
Baricitinib	Inhibitor of Janus kinase (JAK)1 and JAK2	**FDA Emergency Use Authorisation (EUA): Baricitinib in combination with remdesivir** No withdrawn, suspended or terminated studies found
Molnupiravir	Pro-drug of the nucleoside analogue *N*4-hydroxycytidine (NHC)	No withdrawn, suspended or terminated studies found
Ivermectin	Antiparasitic	No withdrawn, suspended or terminated studies found
Aspirin (acetylsalicylic acid)	Antitrombotic	1 RCT withdrawn, no suspended or terminated studies found
Aviptadil (RLF-100)	Synthetic form of Human Vasoactive Intestinal Polypeptide (VIP)	No withdrawn, suspended or terminated studies found

3.1 Remdesivir (Veklury®)

About the drug under consideration

erstes zugelassenes antivirales Medikament gegen Coronavirus: conditional marketing authorisation

Remdesivir (Veklury) is an antiviral medicine for systemic use which received a **conditional marketing authorisation** in **EU** in July, 2020 [78-80], https://ec.europa.eu/commission/presscorner/detail/en/mex_20_1266..

indiziert für Patient*nnen ≥ 12 Jahre mit Lungenentzündung, Sauerstoff-unterstützt Verabreichung iv 5-10 Tage

Remdesivir (Veklury) is **indicated** for the treatment of coronavirus disease 2019 (COVID-19) in adults and adolescents (aged 12 years and older with body weight at least 40 kg) with pneumonia requiring supplemental oxygen. The drug is for administration by intravenous infusion after further dilution. The **recommended dosage** of remdesivir in patients 12 years of age and older and weighing at least 40 kg is: Day 1 – single loading dose of remdesivir 200 mg given by intravenous infusion, Day 2 onwards – 100 mg given once daily by intravenous infusion. The total **duration of treatment** should be at least 5 days and not more than 10 days. **Concomitant use** of remdesivir **with chloroquine phosphate or hydroxychloroquine sulphate** is **not recommended** due to antagonism observed in vitro.

Nebenwirkungen

The **most common adverse reaction** in healthy volunteers is increased transaminases (14%). The most common adverse reaction in patients with COVID-19 is nausea (4%) [81].

Remdesivir (Veklury) is subject to **additional monitoring for safety**. Due to a conditional marketing authorisation, Marketing Authorisation Holder (MAH) should complete some **measures to confirm the efficacy and safety within different timeframe** [63].

Okt 2020: EMA Sicherheitsanalyse

On October 02, 2020 EMA announced that EMA's safety committee (PRAC) has started a review of a safety signal to assess reports of acute kidney injury in some patients with COVID-19 taking Veklury (remdesivir) [82].

FDA Zulassung im Okt 2020

On October 22, 2020 the **U.S. Food and Drug Administration approved** remdesivir for use in adult and pediatric patients 12 years of age and older and weighing at least 40 kilograms (about 88 pounds) for the treatment of **COVID-19 requiring hospitalization**.

FDA Notzulassung für Kombinationstherapie Remdesvir + Baricitinib

The **FDA** recently issued an emergency use authorization (EUA) for the Janus kinase inhibitor **baricitinib** to be used **in combination with remdesivir** in patients with COVID-19 who require oxygen or ventilatory support [83].

WHO empfiehlt Remedisivir nicht, unabhängig von Patientenpopulation basierend auf Ergebnisse aus SOLIDARITY

Recently, the new **WHO living guidance** on remdesivir for COVID-19 was published [84]. The WHO panel made a conditional recommendation against the use of remdesivir in hospitalised patients with COVID-19, regardless of disease severity, with new information and recommendations on remdesivir after publication of results from the WHO SOLIDARITY trial [85]. The recommendation on remdesivir was informed by results from a systematic review and network meta-analysis (NMA) that pooled data from four randomized trials with 7333 participants hospitalized for COVID-19. The resulting GRADE evidence summary suggested that remdesivir has possibly no effect on mortality (odds ratio 0.90, 95% confidence interval [CI] 0.70 - 1.12; absolute effect estimate 10 fewer deaths per 1000 patients, 95% CI from 29 fewer - 11 more deaths per 1000 patients; low certainty evidence); and possibly no effect on the other important outcomes identified by the panel, with similar low to very low certainty of evidence. The panel judged the

overall credibility of subgroup analyses assessing differences in mortality by severity of illness to be insufficient to make subgroup recommendations.

US COVID-19 Treatment Guidelines

US COVID-19 Treatment Guidelines Panel issued new recommendations on remdesivir treatment for patients with COVID-19 (as of February 11, 2021) [86]:

Empfehlung: nicht routinemäßig

Remdesivir, an antiviral agent, is currently the only drug that is approved by the FDA for the treatment of COVID-19. It is recommended for use in hospitalised patients who require supplemental oxygen. However, it is not routinely recommended for patients who require mechanical ventilation due to the lack of data showing benefit at this advanced stage of the disease.

Empfehlungen für bestimmte, genau deinierte Patient*innengruppen

For Hospitalized Patients With COVID-19 Who Require Supplemental Oxygen but Who Do Not Require Oxygen Delivery Through a High-Flow Device, Noninvasive Ventilation, Invasive Mechanical Ventilation, or Extracorporeal Membrane Oxygenation

The Panel recommends one of the following options for these patients:

- **Remdesivir** (e.g., for patients who require minimal supplemental oxygen) **(BIIa)**;
- **Dexamethasone plus remdesivir** (e.g., for patients who require increasing amounts of oxygen) **(BIII)**; **or**
- **Dexamethasone** (e.g., when combination therapy with remdesivir cannot be used or is not available) **(BI)**.

For Hospitalized Patients With COVID-19 Who Require Delivery of Oxygen Through a High-Flow Device or Noninvasive Ventilation but Not Invasive Mechanical Ventilation or Extracorporeal Membrane Oxygenation

The Panel recommends one of the following options for these patients:

- **Dexamethasone** alone **(AI)**; **or**
- A combination of **dexamethasone plus remdesivir (BIII)**.

For Hospitalized Patients With COVID-19 Who Require Invasive Mechanical Ventilation or Extracorporeal Membrane Oxygenation

- The Panel recommends the use of **dexamethasone** in hospitalized patients with COVID-19 who require invasive mechanical ventilation or ECMO **(AI).**
- If dexamethasone is not available, equivalent doses of alternative corticosteroids such as **prednisone**, **methylprednisolone**, or **hydrocortisone** may be used **(BIII)**.
- For patients who initially received remdesivir monotherapy and progressed to requiring invasive mechanical ventilation or ECMO, dexamethasone should be initiated and remdesivir should be continued until the treatment course is completed.
- The Panel recommends against the use of remdesivir monotherapy **(AIIa)**.

Vorhaben von Gilead: Darreichungsform mittels Inhalator

Gilead Sciences Inc. said it plans to start human trials of an inhaled version of its anti-Covid-19 drug remdesivir. An inhaled version, through a nebulizer, could allow Gilead to give the drug to a broader group of patients, including those with milder symptomatic cases who don't need to be hospitalised, https://www.pharmacist.com/article/gilead-begin-human-testing-inhaled-version-covid-19-drug-remdesivir.

Withdrawn, suspended or terminated studies

The two phase 3 randomised controlled trials (RCT) to evaluate intravenous RVD in patients with 2019-nCoV, initiated in the beginning of February in China, are suspended (NCT04252664) or terminated (NCT04257656) (the epidemic of COVID-19 has been controlled well in China, and no eligible patients can be enrolled further).

in ClinicalTrials.gov & EUdraCT keine weiteren beendeten Studien

Results of publications

Ergebnisse der Studien:

Wang Y et al. 2020 [87] published results of the first randomised, double-blind, placebo-controlled, multicentre trial, conducted in China (**NCT04257656**), on intravenous remdesivir in adults admitted to hospital with severe COVID-19. The study was terminated before attaining the prespecified sample size (237 of the intended 453 patients were enrolled) because the outbreak of COVID-19 was brought under control in China. Remdesivir treatment was not associated with a statistically significant difference in time to clinical improvement (hazard ratio 1·23 [95% CI 0·87–1·75]); duration of invasive mechanical ventilation; viral load; adverse events.

Wang (Hubei/ China): frühzeitig beendet wegen Mangel an Pts.

keine Unterschiede bei klinischer Verbesserung, invasiver Beatmung

Beigel et al. 2020 [88] reported results from double-blind, randomized, placebo-controlled trial of intravenous remdesivir in 1062 adults hospitalized with Covid-19 (541 assigned to remdesivir and 521 to placebo) (**NCT04280705**). Remdesivir group had a median recovery time of 10 days (95% confidence interval [CI], 9 to 11) vs 15 days (95% CI, 13 to 18) among placebo group (rate ratio for recovery, 1.29; 95% CI, 1.12 to 1.49; P<0.001, by a log-rank test). The rate ratio for recovery was largest among patients with a baseline ordinal score of 5 (rate ratio for recovery, 1.45; 95% CI, 1.18 to 1.79). The Kaplan–Meier estimates of mortality were 6.7% with remdesivir vs 11.9% in placebo group by day 15 (hazard ratio, 0.55; 95% CI, 0.36 to 0.83); 11.4% with remdesivir vs 15.2% with placebo by day 29 (hazard ratio, 0.73; 95% CI, 0.52 to 1.03). The between group differences in mortality varied considerably according to baseline severity, with the statisticaly significant difference seen among patients with a baseline ordinal score of 5 (hazard ratio, 0.30; 95% CI, 0.14 to 0.64). Serious adverse events were reported in 131 of the 532 patients who received remdesivir (24.6%) and in 163 of the 516 patients who received placebo (31.6%). There were 47 serious respiratory failure adverse events in the remdesivir group (8.8% of patients), including acute respiratory failure and the need for endotracheal intubation, and 80 in the placebo group (15.5% of patients). No deaths were considered by the investigators to be related to treatment assignment.

Beigel (USA)
1.062 Pts.
kürzere Dauer zur Erholung

Unterschiede bei Baseline-Schwergrad erschweren die Interpretation der Mortalitätsdaten

Goldman et al. 2020 [89] published the results from the randomized, open-label, phase 3 trial involving 397 hospitalized patients with confirmed SARS-CoV-2 infection, oxygen saturation of 94% or less while they were breathing ambient air, and radiologic evidence of pneumonia (**NCT04292899**), to receive intravenous remdesivir for either 5 days or 10 days. Trial did not show a significant difference between a 5-day course and a 10-day course of remdesivir. -The most common adverse events were nausea (9% of patients), worsening respiratory failure (8%), elevated alanine aminotransferase level (7%), and constipation (7%). The absence of a control group in this study did not permit an overall assessment of the efficacy of remdesivir.

Goldman (USA, IT, SP…)
RCT, open-label
397 Pts.

Vergleich von 5 vs. 10 Tagen RDV

primärer Endpunkt: klinischer Status am Tag 14

Spinner et al. 2020 [90] published results from a randomised, open-label, phase 3 trial (**NCT04292730**) performed on 596 hospitalised patients with moderate COVID-19 pneumonia (pulmonary infiltrates and room-air oxygen saturation >94%). Patients were randomized in a 1:1:1 ratio to receive a 10-day course of remdesivir (n = 197), a 5-day course of remdesivir (n = 199), or standard care (n = 200). On day 11, patients in the 5-day remdesivir group had statistically significantly higher odds of a better clinical status distribution vs standard care (odds ratio, 1.65; 95% CI, 1.09-2.48; p=0.02), but the difference was of uncertain clinical importance. The clinical status distribution on day 11 between the 10-day remdesivir and standard care groups was not significantly different (p=0.18 by Wilcoxon rank sum test).

Spinner (USA, Europa, Asien)

5-Tage vs 10-Tage vs. SOC

There were no significant differences between the 5-day or 10-day remdesivir groups and standard care for any of the exploratory end points—time to 2-point or greater improvement in clinical status, time to 1-point or greater improvement in clinical status, time to recovery, time to modified recovery, and time to discontinuation of oxygen support, duration of oxygen therapy or hospitalization and all-cause mortality at day 28. The difference in AEs proportions between the 5-day remdesivir group and standard care was not statistically significant (4.8%; 95% CI, –5.2% to 14.7%; p=0.36), but the difference between the 10-day remdesivir group and standard care was significant (12.0%; 95% CI, 1.6%-21.8%; p=0.02). Nausea (10% vs 3%), hypokalemia (6% vs 2%), and headache (5% vs 3%) were more frequent among remdesivir-treated patients compared with standard care. Serious adverse events were less common in the remdesivir groups, but the difference was not statisticaly significant.

596 Pts
kein signifikanter Unterschied zwischen 5 vs. 10 Tage vs. SOC

AE signifikanter Unterschied zwischen 10 Tage vs. SOC zu Ungunsten von Remdesivir
SAE häufiger in SOC Gruppe

Interim results from the **WHO SOLIDARITY trial (ISRCTN83971151, NCT04315948),** large, international, adaptive, open-label, randomized controlled trial to evaluate remdesivir, lopinavir/ritonavir, interferon beta-1a and hydroxychloroquine treatment for COVID-19, were published, with 2750 patients allocated to remdesivir [85, 91]. Death rate ratio was not statisticaly significant different between remdesivir and standard care; RR=0.95 (0.81-1.11, p=0.50; 301/2743 active vs 303/2708 control). The same was true for the outocmes: initiation of ventilation and hospitalisation duration, and other three investigation treatment.

WHO SOLIDARITY

kein Unterschied bei Mortalität
kein Unterschied bei anderen Endpunkten

Barratt-Due et al. 2021 [92] published results (as preprint) from NOR-Solidarity (NCT04321616), an independent add-on study to the WHO Solidarity trial. 4185 patients from 23 hospitals in Norway were randomized and 181 included in the full analysis set: remdesivir (n=42), HCQ (n=52) and SoC (n=87). No significant differences in mortality during hospitalisation, ICU admission or occurrence of mechanical ventilation between the treatment groups and SoC were observed. There was a marked decrease in SARS-CoV-2 load in oropharynx during the first week with similar decrease and 10-day levels between remdesivir, HCQ and their respective SoC. Remdesivir and HCQ did not exert any effect on the degree of respiratory failure or on inflammatory parameters in peripheral blood. The lack of anti-viral effect was not associated with symptom duration, level of viral load or presence of antibodies against SARS-CoV-2 at hospital admittance.

NOR-Solidarity
4185 Pts
kein Unterschied bei Mortalität, ICU, künstliche Beatmung

EUnetHTA Bericht zu 4 RCTs (Dez 2020):

kein Unterschied: all-cause mortality

Unterschied bei klinischer Verbesserung und bei Nebenwirkungen

Based on the **living synthesis** of currently available scientific evidence from **4 RCTs** (Wang, Beigel, Spinner and SOLIDARITY-Remdesivir), on remdesivir compared with standard care/placebo, presented in recently published EUnetHTA Rapid Collaborative Review document [93], current scientific conclusions were listed: According to the results of four RCTs with moderate certainty of evidence, remdesivir has no effect on mortality in COVID-19 patients compared to standard treatment; According to the results of three RCTs, remdesivir decreases the incidence of WHO progression score level 6 or above (moderate certainty of evidence), as well as the WHO progression score level 7 or above D14-D28 (high certainty of evidence), compared to standard treatment; According to the results of one RCT with very low certainty of evidence, remdesivir has no effect on viral clearance, compared to standard treatment; According to the results of three RCTs with moderate certainty of evidence, remdesivir increases the number of discharged patients within 28 days compared to standard treatment; According to low certainty of evidence, remdesivir has no effect on outcomes mechanical ventilation (4 RCTs); time to clinical improvement (3 RCTs); duration of ventilation (2RCTs); duration of hospitalisation (3 RCTs) and serious adverse events leading to discontinuation (3 RCTs), compared to standard treatment; According to the results of two RCTs with high certainty of evidence, remdesivir does not increase adverse events compared to standard treatment; According to the results of three RCTs with moderate certainty of evidence, remdesivir decreases the number of patients with SAEs compared to standard treatment.

Details can be found in the **Summary of findings Table** 3.1-1.

The Living Systematic Review with Meta-Analysis (MA), related to Remdesivir 5 days vs Remdesivir 10 days (2 RCTs, Spinner and Goldman) and the Summary of findings table (https://covid-nma.com/living_data/index.php) are presented in Table 3.1-2.

*Table 3.1-1: Summary of findings table on **Remdesivir vs Standard care / Placebo** (4 RCTs: Wang, Beigel, Spinner, SOLIDARITY-Remdesivir)*

Patient or population: *Mild/Moderate/Severe/Critical COVID-19*
Setting: Wordwide
Intervention: Remdesivir
Comparison: Standard Care/Placebo

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect difference (95% CI)	Number of participants (studies)	Certainty of evidence[e] (GRADE)	Comments
	Risk with Standard care[a]	Risk with Remdesivir					
All-cause Mortality[b]	112 per 1.000	**101 per 1.000** (82 to 125)	**RR 0.90** (0.73 to 1.11)	**11 fewer per 1.000** (from 30 fewer to 12 more)	7345 (4 RCTs) Spinner, 2020; SOLIDARITY 2020; Beigel, 2020; Wang, 2020[94][94][94][94]	⊕⊕⊕◯ MODERATE	Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of events
Clinical improvement D14-D28b	759 per 1.000	**805 per 1.000** (751 to 858)	**RR 1.06** (0.99 to 1.13)	**46 more per 1.000** (from 8 fewer to 99 more)	832 (2 RCTs) Spinner, 2020; Wang, 2020	⊕⊕⊕◯ MODERATE	Imprecision downgraded by 1 level: due to low number of events and/or participants
WHO progression score (level 6 or above) D14-D28b	193 per 1.000	**131 per 1.000** (106 to 164)	**RR 0.68** (0.55 to 0.85)	**62 fewer per 1.000** (from 87 fewer to 29 fewer)	1894 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⊕⊕⊕◯ MODERATE	Risk of bias downgraded by 1 level: some concerns due to deviation from intended intervention and outcome measurement
WHO progression score level 7 or above D14-28b	178 per 1.000	**124 per 1.000** (100 to 156)	**RR 0.70** (0.56 to 0.88)	**53 fewer per 1.000** (from 78 fewer to 21 fewer)	1894 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⊕⊕⊕⊕ HIGH	
Viral negative conversion D7b	492 per 1.000	**502 per 1.000** (374 to 679)	**RR 1.02** (0.76 to 1.38)	**10 more per 1.000** (from 118 fewer to 187 more)	196 (1 RCT) Wang, 2020	⊕◯◯◯ VERY LOW	Risk of bias downgraded by 1 level: some concerns with missing data Indirectness downgraded by 1 level: despite a multicenter design this is a single study from a single country, therefore results in this population might not be generalizable to other settings

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect difference (95% CI)	Number of participants (studies)	Certainty of evidence[e] (GRADE)	Comments
	Risk with Standard care[a]	Risk with Remdesivir					
							Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of events
Adverse eventsb	583 per 1.000	**542 per 1.000** (496 to 589)	**RR 0.93** (0.85 to 1.01)	**41 fewer per 1.000** (from 87 fewer to 6 more)	1894 (2 RCTs) Wang, 2020; Beigel, 2020;	⊕⊕⊕⊕ HIGH	Presume that the adverse event rates, and the corresponding relative risks, are similar across diverse settings; therefore not downgraded for indirectness
Serious adverse eventsb	40 per 1.000	**24 per 1.000** (15 to 38)	**RR 0.60** (0.38 to 0.96)	**16 fewer per 1.000** (from 25 fewer to 2 fewer)	1894 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⊕⊕⊕◯ MODERATE	Presume that the adverse event rates, and the corresponding relative risks, are similar across diverse settings; therefore not downgraded for indirectness Imprecision downgraded by 1 level: few events and a wide confidence interval consistent with the possibility of a benefit and the possibility of no effect.
Serious adverse events leading to discontinuation c	*15* per 1.000	*15* per 1000	**OR 1.00** (0.37 - 3.83)	***0 fewer per 1.000*** (from 9 fewer to 40 more)	1894 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⊕⊕◯◯ **Low**	Very serious imprecision
Mechanical ventilation [c]	*105* per 1000	*95* per 1000	**OR: 0.89** (0.76 - 1.03)	***10 fewer per 1000*** (from 23 fewer to 3 more)	6549 (4 RCTs) Spinner, 2020; SOLIDARITY, 2020; Beigel, 2020; Wang, 2020	⊕⊕◯◯ Low	Due to serious risk of bias and serious imprecision
Duration of ventilation c	*14.7* Days mean	*13.4* Days mean	Measured by: Scale: lower better	Difference: ***MD 1.3 lower*** (from 4.1 lower to 1.5 higher)	440 (2 RCTs) Wang, 2020; Beigel, 2020;	⊕⊕◯◯ Low	Due to very serious imprecision

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect difference (95% CI)	Number of participants (studies)	Certainty of evidence[e] (GRADE)	Comments
	Risk with Standard care[a]	Risk with Remdesivir					
Time to clinical improvement c	*11.0* Days mean	*9.0* Days mean	Measured by: Scale: lower better	Difference: ***MD 2.0 lower*** (from 4.2 lower to 0.9 higher)	1882 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⨁⨁◯◯ *Low*	Due to serious imprecision and serious indirectness
Duration of hospitalization c	*12.8* Days mean	*12.3* Days mean	Measured by: Scale: lower better	Difference: ***MD 0.5 lower*** (from 3.3 lower to 2.3 higher)	1882 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⨁⨁◯◯ *Low*	Due to serious imprecision and serious indirectness
Number of patients discharged within 28 days d	478 per 1.000	**540 per 1,000** (488 to 593)	**RR 1.13** (1.02 to 1.24)	**62 more per 1.000** (from 10 more to 115 more)	1894 (3 RCTs) Beigel, 2020; Spinner, 2020; Wang, 2020	⨁⨁⨁◯ MODERATE	Downgraded of one level for high risk of performance bias in two studies and unclear risk of selection, attrition and reporting bias in one study

Source: [93] [90] [85] [88] [87]

a Background risk in the control group is based on the observed risk in the studies; b outcome data and GRADE assessment from Covid-nma.com, https://covid-nma.com/living_data/index.php (The evidence profile and summary of findings table were updated on November 17th, 2020); C Outcome data and GRADE assessment from WHO guideline [84] d Outcome data and GRADE assessment from the department of Epidemiology Lazio Regional Health Service (DEPLazio), Italy, http://deplazio.net/farmacicovid/index.html;e GRADE Working Group grades of evidence: High certainty=we are very confident that the real effect is close to that of the estimated effect; Moderate certainty=we are moderately confident in the effect estimation: the real effect may be close to the estimated effect, but there is a possibility that it is substantially different; Low certainty=our confidence in the effect estimation is limited: the real effect may be substantially different from the estimated effect; Very Low certainty=we have very little confidence in estimating the effect: the actual effect is likely to be substantially different from the estimated one.

Abbreviations: CI= confidence interval; RR=relative risk; OR=odds ratio.

GRADE Working Group grades of evidence: **High certainty:** We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Table 3.1-2: Summary of findings table on ***Remdesivir 5 days vs Remdesivir 10 days*** *(2 RCTs: Goldman, Spinner) - https://covid-nma.com/living_data/index.php*

Remdesivir 5 days compared to Remdesivir 10 days for Mild/Moderate/Critical/Severe Covid-19

Patient or population: Mild/Moderate/Critical/Severe Covid-19
Setting: Worldwide
Intervention: Remdesivir 5 days
Comparison: Remdesivir 10 days

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Remdesivir 10 days	Risk with Remdesivir 5 days				
Incidence of viral negative conversion D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Incidence of clinical improvement D7	368 per 1.000	**438 per 1.000** (371 to 515)	**RR 1.19** (1.01 to 1.40)	798 (2 RCTs) [b]	⨁⨁◯◯ LOW [c,d]	
Incidence of clinical improvement D14-28	708 per 1.000	**750 per 1.000** (616 to 920)	**RR 1.06** (0.87 to 1.30)	798 (2 RCTs) [b]	⨁◯◯◯ VERY LOW [c,e,f]	
Incidence of WHO progression score (level 6 or above) D14-28	174 per 1.000	**109 per 1.000** (78 to 153)	**RR 0.63** (0.45 to 0.88)	798 (2 RCTs) [b]	⨁⨁◯◯ LOW [c,d]	
Incidence of WHO progression score (level 7 or above) D14-28	146 per 1.000	**85 per 1.000** (58 to 124)	**RR 0.58** (0.40 to 0.85)	798 (2 RCTs) [b]	⨁⨁◯◯ LOW [c,g]	
All-cause mortality D14-28	60 per 1.000	**45 per 1.000** (25 to 81)	**RR 0.74** (0.41 to 1.34)	798 (2 RCTs) [b]	⨁⨁◯◯ LOW [f,g]	
Adverse events	650 per 1.000	**604 per 1.000** (546 to 669)	**RR 0.93** (0.84 to 1.03)	798 (2 RCTs) [b]	⨁⨁⨁◯ MODERATE [c]	
Serious adverse events	196 per 1.000	**126 per 1.000** (92 to 171)	**RR 0.64** (0.47 to 0.87)	798 (2 RCTs) [b]	⨁⨁◯◯ LOW [c,d]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

a. Last update: September 18, 2020; b. Spinner CD, 2020; Goldman JD, 2020; c. Risk of bias downgraded by 1 level: some concerns due to concerns during the randomization process, deviation from intended intervention and outcome measurement; d. Imprecision downgraded by 1 level: due to low number of events and/or participants; e. Inconsistency downgraded by 1 level: I^2= 79.3%
f. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm; g. Risk of bias downgraded by 1 level: some concerns due to concerns during the randomization process and deviation from intended intervention

3.2 Lopinavir + Ritonavir (Kaletra®)

wegen erwiesenem Mangel an Wirksamkeit wurde Beobachtung beendet

Due to the lack of effectiveness of lopinavir/ritonavir in treating adults hospitalized with COVID-19 patients and the decisions to stop enrolling participants to the lopinavir/ritonavir (Kaletra) arms of the RECOVERY, SOLIDARITY and DISCOVERY studies in adults hospitalized with COVID-19, our reporting related to lopinavir/ritonavir was stopped also.

Last reporting V6/September 2020:
https://eprints.aihta.at/1234/50/Policy_Brief_002_Update_09.2020.pdf

3.3 Favipiravir (Avigan®)

About the drug under consideration

antivirales Medikament

Favipiravir (Avigan®), an antiviral drug, is a new type of RNA-dependent RNA polymerase (RdRp) inhibitor [95, 96].

Favipiravir (Avigan®) has not been approved by the European Medicines Agency (EMA) or the American Food and Drug Administration (FDA) for COVID-19.

Empfehlungen des US COVID-19 Treatment Guidelines Panel GEGEN jegliche HIV Protease Inhibitoren

The US COVID-19 Treatment Guidelines Panel **recommends against** using the **Lopinavir/ritonavir (AI) or other HIV protease inhibitors (AIII),** except in a clinical trial, because of unfavorable pharmacodynamics and because clinical trials have not demonstrated a clinical benefit in patients with COVID-19 [86].

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated RCTs were found in two clinical trial registers (ClinicalTrials.gov and EUdraCT).

Results of publications

1 Publikation zu RCT Vergleich mit Umifenovir

Chen C et al. 2020 [97] published results (as preprint) on a RCT (**ChiCTR2000030254**) related to efficacy and safety of favipiravir, **in comparison with umifenovir.** Summary of findings table on favipiravir compared to umifenovir (1 RCT: Chen) is presented in Table 3.3-1.

1 weitere Publikation Vergleich mit Baloxavir marboxil

Lou Y et al. 2020, published as preprint results of exploratory RCT with 3 arms (**ChiCTR2000029544**) [98] related to the efficacy and safety of favipiravir **in comparison with baloxavir marboxil**, and **lopinavir + ritonavir or darunavir/cobicistat + umifenovir + interferon-a** in hospitalized adult patients with COVID-19. The percentage of patients who turned viral negative after 14-day treatment was 70%, 77%, and 100% in the baloxavir, favipiravir, and control group respectively, with the medians of time from randomization to clinical improvement was 14, 14 and 15 days, respectively.

Summary of findings table on favipiravir compared to baloxavir marboxil is presented in Table 3.3-2 and favipiravir compared to lopinavir + ritonavir or darunavir/cobicistat + umifenovir + interferon-a (1 RCT: Lou 2020) [69] is presented in Table 3.3-3.

Interim results from an adaptive, multicenter, open label, randomized, phase 2/3 clinical trial (NCT04434248) of favipiravir (AVIFAVIR) **versus standard of care** (SOC) in 60 hospitalized patients with moderate COVID-19 pneumonia were published (three treatment groups: AVIFAVIR 1600/600 mg, AVIFAVIR 1800/800 mg, or SOC). AVIFAVIR enabled SARS-CoV-2 viral clearance in 62.5% of patients within 4 days, and was safe and well-tolerated. Based on these interim results, the Russian Ministry of Health granted a conditional marketing authorization to AVIFAVIR, which makes it the only approved oral drug for treatment of moderate COVID-19 to date [99].

AVIFAVIR
Phase 2/3 RCT bei moderater Covid-19 Erkrankung

interim Auswertung orale Verabreichung in Russland „conditional" zugelassen

Dabbous et al. 2020 published results, as preprint, from open-label, phase 3 RCT, comparing **favipiravir vs standard care** (hydroxychloroquine plus oseltamivir) in 100 patients with mild to moderate COVID-19 in Egypt (NCT04349241) [100]. No statistically significant difference was found related to time to PCR negativity (p=0.7). Four patients in favipiravir group had increase in liver transaminase, and 20 patients in standard care group (hydroxychloroquine plus oseltamivir) developed heartburn and nausea. One patient died in hydroxychloroquine plus oseltamivir group after acute myocarditis resulted in acute heart failure.

Phase 3 RCT (Ägypten)
kein Unterschied

Balykova et al. 2020 [101] published results from a RCT in 200 hospitalised patients with COVID-19 showed a signifiant advantage of favipiravir therapy compared with standard therapy in terms of the rate of improvement in clinical status (on average by 4 days), the speed and frequency of recovery on the 10 day of therapy (no clinical signs of the disease in the study and control groups were observed in 44 and 10% of patients, respectively), the frequency of achieving the viral clearance on the 10th day of therapy (98 and 78% in the study and control groups, respectively) (p=0.00003). Favipiravir therapy was accompanied by a significant improvement in lung condition according to CT data, improved laboratory parameters and normalization of oxygen saturation levels. Favipiravir therapy was characterized by a favorable safety profie. In the main group, no aggravation of the course of the disease or serious adverse events related to the drug were recorded.

RCT
200 hospitalisierte Patient*innen

raschere klinische Verbesserung (-4 Tage), insb. der Lunge

akzeptables Sicherheitsprofil

Ruzhentsova et al. 2020 [102] published results as preprint from open-labeled, randomized, active-controlled multicenter trial (NCT04501783) of an oral dosage form of favipiravir in out- and hospitalized patients with mild to moderate COVID-19 in 10 clinical centers in Russia. 190 Patients were randomly assigned (in a 2:1 ratio) to receive either favipiravir (1800 mg BID on day 1, followed by 800 mg BID for up to 9 days), or standard of care (SOC) treatment (umifenovir + intranasal interferon alpha-2b, or hydroxychloroquine) for up to 10 days. The median time to clinical improvement was 6.0 (IQR 4·0; 9·3) days in favipiravir group and 10.0 (IQR 5·0; 21·0) days in SOC group; the median difference was 4 days (HR 1·63; 95% CI 1·14-2·34, p=0·007). The statistically significant difference in the median time to viral clearance was observed only in the hospitalized cohort of patients: 3·0 (IQR 3·0; 3·0) vs. 5·0 (IQR 4·5; 5·5), respectively (HR 2·11; 95% CI 1·04-4·31; p = 0·038). However, the rate of viral elimination on Day 5 in the favipiravir group was significantly higher in the whole population: 81·2% vs. 67·9% respectively (RR 1·22; 05% CI 1·00-1·48; p = 0.022). The rate of clinical improvement on Day 7 in the favipiravir group was 1.5-fold higher compared to SOC: 52·7% vs. 35·8% (RR 1·50; 95% CI 1·02-2·22; p = 0·020). Favipiravir was well tolerated: most of the adverse events (AE) were mild. Any AEs were reported in 74·1% of patients in the favipiravir group vs. 60·0% in the SOC group; the most common adverse reactions were asymptomatic hyperuricemia,

RCT
190 Patient*innen
milde oder moderate Erkrankung

ambulante oder hospitalisiert

Vergleich mit SOC (umifenovir + intranasal interferon alpha-2b, or hydroxychloroquine)

raschere Reduktion der Viruslast und klinische Verbesserung mit favipiravir

akzeptables Sicherheitsprofil

transient elevation of ALT & AST, and gastrointestinal disorders (diarrhea, nausea, abdominal pain).

Udwadia et al. 2020 [103] published results from randomized, open-label, parallel-arm, multicenter, phase 3 trial (CTRI/2020/05/025114), in adults with mild to moderate COVID-19 in India. 150 patients were randomized to favipiravir (n=75) or control (n=75). Median time to cessation of viral shedding was 5 days (95% CI: 4 days, 7 days) versus 7 days (95% CI: 5 days, 8 days), p=0.129, and median time to clinical cure was 3 days (95% CI: 3 days, 4 days) versus 5 days (95% CI: 4 days, 6 days), p=0.030, for favipiravir and control respectively. Adverse events were observed in 36% of favipiravir and 8% of control patients. One control patient died due to worsening disease.

RCT
150 Patient*innen
milde oder moderate Erkrankung

raschere Reduktion der Viruslast und klinische Verbesserung mit favipiravir

Solaymani-Dodaran et al. 2021 [104] published negative results from multicenter randomized open-labeled clinical trial on moderate to severe cases infections of SARS-CoV-2. 380 patients were randomly allocated into favipiravir (193) and lopinavir/ritonavir (187) groups in 13 centers. The number of deaths, intubations, and ICU admissions were not significantly different (26, 27, 31 and 21, 17, 25 respectively). Mean hospital stay was also not different (7.9 days [SD=6] in the Favipiravir and 8.1 [SD=6.5] days in Lopinavir/Ritonavir groups) (p=0.61). Time to clinical recovery in the Favipiravir group was similar to Lopinavir/Ritonavir group (HR=0.94, 95% CI 0.75 – 1.17) and likewise the changes in the daily SpO2 after discontinuation of supplemental oxygen (p=0.46). Adding Favipiravir to the treatment protocol did not reduce the number of ICU admissions or intubations or In-hospital mortality compared to Lopinavir/Ritonavir regimen. It also did not shorten time to clinical recovery and length of hospital stay.

RCT
380 Patient*innen
favipiravir vs. lopinavir/ritonavir
kein Unterschied bei Mortalität, ICU, Spitalsaufenthalt

Data related to **Summary of findings table** on **favipiravir compared to standard care** (6 RCTs: Lou 2020, Ivashchenko 2020, Dabbous 2020, Balykova 2020, Ruzhentsova 2020, Udwadia 2020) could be found in Table 3.3-4 below. Based on currently available evidence, favipiravir may not increase the incidence of Clinical improvement D28 (6 RCTs, RR 1.02, 95% CI 0.95 to 1.09, low certainty of evidence). The evidence is very uncertain about the effect of favipiravir on All-cause mortality D28 (RR 0.33, 95%CI 0.04 to 3.16, 4 RCTs, very low certainty of evidence); Viral negative conversion D7 (RR 1.10, 95%CI 0.96 to 1.27, 6 RCTs, low certainty of evidence); Adverse events (RR 1.54, 95%CI 0.87 to 2.75, 4 RCTs, very low certainty of evidence) and Serious adverse events (RR 1.20, 95%CI 0.48 to 3.00, 4 RCTs, very low certainty of evidence).

Zusammenfassung von 6 RCTs
ev. Effekte auf klinische Verbesserung
Mortalität

Doi et al. 2020 published results from RCT (Japan Registry of Clinical Trials **jRCTs041190120**), related to early versus late favipiravir in hospitalised patients with COVID-19 [105]. 88 patients were randomly assigned at a 1:1 ratio to **early or late favipiravir therapy** (the same regimen starting on day 6 instead of day 1). Viral clearance occurred within 6 days in 66.7% and 56.1% of the early and late treatment groups (adjusted hazard ratio [aHR], 1.42; 95% confidence interval [95% CI], 0.76–2.62). Of 30 patients who had a fever (≥37.5°C) on day 1, time to defervescence was 2.1 days and 3.2 days in the early and late treatment groups (aHR, 1.88; 95%CI, 0.81–4.35). During therapy, 84.1% developed transient hyperuricemia. Neither disease progression nor death occurred to any of the patients in either treatment group during the 28-day participation.

Okt 2020:
RCT mit 89 Pts.
Japan
Vergleich von früher und später Favipiravir Therapie bei hospitalisierten Pts.

kein Unterschied

Zhao H et al. 2020, published results from RCT in moderate to critical COVID-19 patients in China, comparing **favipiravir to tocilizumab and favipiravir plus tocilizumab (ChiCTR2000030096, NCT04310228)** [106]. Patients were randomly assigned (3:1:1) to a 14-day combination of favipiravir combined with tocilizumab (combination group), favipiravir, and tocilizumab. The cumulative lung lesion remission rate at day 14 was significantly higher in the combination group as compared with favipiravir group (p = 0.019, HR 2.66 95% CI [1.08 to 6.53]); a significant difference between tocilizumab and favipiravir found also (p = 0.034, HR 3.16, 95% CI 0.62 to 16.10). There was no significant difference between the combination group and the tocilizumab group (p = 0.575, HR 1.28 95%CI 0.39 to 4.23). Combined therapy can also significantly relieve clinical symptoms and help blood routine to return to normal. No serious adverse events were reported.

RCT
19 Patient*innen
favipiravir + tocilizumab vs. favipiravir vs. tocilizumab

Kombinationstherapie von Vorteil

Dabbous et al. 2021 published results from multi-center, randomized, interventional phase 2 / 3 study that included 96 mild to moderate COVID-19 patients with confirmed SARS-CoV-2 infection (NCT04351295) [107]. 96 patients were randomly assigned into two groups. The chloroquine (CQ) group included 48 patients who received chloroquine 600 mg tablets twice daily added to the standard-of-care therapy for 10 days. The favipiravir group included 48 patients who received 1600 mg of favipiravir twice a day on the first day and 600 mg twice a day from the second to tenth day, added to the standard-of-care therapy for 10 days. No significant differences were observed regarding duration of hospital stay, need of mechanical ventilation, side effects. Two patients (4.2%) in the CQ group and one (2.3%) in the favipiravir group died (p=1.00).

2/ 3 RCT
96 Patient*innen
milde/moderate Erkrankung
keine Unterschiede

Table 3.3-1: Summary of findings table on ***favipiravir compared to umifenovir*** *(1 RCT: Chen) - https://covi-nma.com/living_data/index.php)*

Summary of findings:						
Favipiravir compared to Umifenovir for COVID-19						
Patient or population: COVID-19 **Setting**: Worldwide **Intervention**: Favipiravir **Comparison**: Umifenovir						
Outcomes	**Anticipated absolute effects*** **(95% CI)**		**Relative effect (95% CI)**	**№ of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Risk with Umifenovir	**Risk with Favipiravir**				
Incidence viral negative conversion D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement - not reported	-	-	-	-	-	outcome not yet measured or reported
Incidence of clinical recovery D7	517 per 1.000	**594 per 1.000** (470 to 744)	**RR 1.15** (0.91 to 1.44)	240 (1 RCT)	⨁◯◯◯ VERY LOW [a,b,c]	
Incidence of WHO progression score (level 6 or above) - not reported	-	-	-	-	-	outcome not yet measured or reported
Incidence of WHO progression score (level 7 or above) - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D7				240 (1 RCT)	⨁◯◯◯ VERY LOW [b,d,e]	zero events in both groups
Adverse events D7	275 per 1.000	**358 per 1.000** (245 to 523)	**RR 1.30** (0.89 to 1.90)	240 (1 RCT)	⨁⨁◯◯ LOW [a,c,f]	

Serious adverse events D7		240 (1 RCT)	⊕◯◯◯ VERY LOW [a,d,f]	zero events in both groups

*__The risk in the intervention group__ (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

a. Risk of bias downgraded by 1 level: some concerns or high risk regarding adequate randomization, deviations from intended interventions and outcome measurement

b. Indirectness downgraded by 1 level: single study from a single country, therefore results in this population might not be generalizable to other settings

c. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants

d. Imprecision downgraded by 2 levels: no events in both groups and low number of participants

e. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization and deviations from intended interventions

f. We presume that the adverse event rates, and the corresponding relative risks, is similar across diverse settings; therefore not downgraded for indirectness

Table 3.3-2: Summary of findings table on ***favipiravir compared to baloxavir marboxil*** *(1 RCT: Lou 2020) [69] -* https://covid-nma.com/living_data/index.php

Favipiravir compared to Baloxavir marboxil for Mild/COVID-19

Patient or population: Mild/COVID-19
Setting: Worldwide
Intervention: Favipiravir
Comparison: Baloxavir marboxil

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Baloxavir marboxil	Risk with Favipiravir				
Incidence viral negative conversion D7	600 per 1.000	**402 per 1.000** (162 to 996)	**RR 0.67** (0.27 to 1.66)	20 (1 RCT)	⨁◯◯◯ VERY LOW [a,b,c]	
Incidence clinical Improvement D7	100 per 1.000	**200 per 1.000** (21 to 1.000)	**RR 2.00** (0.21 to 18.69)	20 (1 RCT)	⨁◯◯◯ VERY LOW [b,c,d]	
Incidence clinical Improvement D14-D28	600 per 1.000	**498 per 1.000** (222 to 1.000)	**RR 0.83** (0.37 to 1.85)	20 (1 RCT)	⨁◯◯◯ VERY LOW [b,c,d]	
Incidence of WHO progression score (level 6 or above D14-D28)	100 per 1.000	**33 per 1.000** (2 to 732)	**RR 0.33** (0.02 to 7.32)	20 (1 RCT)	⨁◯◯◯ VERY LOW [b,c,d]	
Incidence of WHO progression score (level 7 or above D14-D28)	100 per 1.000	**33 per 1.000** (2 to 732)	**RR 0.33** (0.02 to 7.32)	20 (1 RCT)	⨁◯◯◯ VERY LOW [a,b,c]	
All-cause mortality D7				20 (1 RCT)	⨁◯◯◯ VERY LOW [a,b,e]	zero events in both groups
All-cause mortality D14-D28				20 (1 RCT)	⨁◯◯◯ VERY LOW [a,b,e]	zero events in both groups
Adverse events - not reported	-	-	-	-	-	outcome not yet measured or reported
Serious adverse events D14-D28	600 per 1.000	**402 per 1.000** (162 to 996)	**RR 0.67** (0.27 to 1.66)	20 (1 RCT)	⨁⨁◯◯ LOW [d,f,g]	

***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviations from intended interventions and selection of the reported results; b. Indirectness downgraded by 1 level: single study from a single institution, therefore results in this population might not be generalizable to other settings; c. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants; d. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviations from intended interventions, measurement of the outcome and selection of the reported results; e. Imprecision downgraded by 2 levels: no events in both groups and very low number of participants; f. Indirectness not downgraded: we presume that adverse event rate is not specific to a certain setting; g. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants

Table 3.3-3: Summary of findings table on favipiravir ***compared to lopinavir + ritonavir or darunavir/cobicistat + umifenovir + interferon-a*** *(1 RCT: Lou 2020) [69] - https://covid-nma.com/living_data/index.php*

Favipiravir compared to Lopinavir + Ritonavir or Darunavir/Cobicistat + Umifenovir + Interferon-a for Mild/COVID-19

Patient or population: Mild/COVID-19
Setting: Worldwide
Intervention: Favipiravir
Comparison: Lopinavir + Ritonavir or Darunavir/Cobicistat + Umifenovir + Interferon-a

Outcomes	Anticipated absolute effects* (95% CI) Risk with Lopinavir + Ritonavir or Darunavir/Cobicistat + Umifenovir + Interferon-a	Risk with Favipiravir	Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
Incidence viral negative conversion D7	500 per 1.000	**400 per 1.000** (150 to 1.000)	**RR 0.80** (0.30 to 2.13)	20 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,c]	
Incidence clinical Improvement D7	100 per 1.000	**200 per 1.000** (21 to 1.000)	**RR 2.00** (0.21 to 18.69)	20 (1 RCT)	⊕◯◯◯ VERY LOW [b,c,d]	
Incidence clinical Improvement D14-D28	500 per 1.000	**500 per 1.000** (210 to 1.000)	**RR 1.00** (0.42 to 2.40)	20 (1 RCT)	⊕◯◯◯ VERY LOW [b,c,d]	
Incidence of WHO progression score (level 6 or above D14-D28)				20 (1 RCT)	⊕◯◯◯ VERY LOW [b,d,e]	zero events in both groups
Incidence of WHO progression score (level 7 or above D14-D28)				20 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,e]	zero events in both groups
All-cause mortality D7				20 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,e]	zero events in both groups
All-cause mortality D14-D28				20 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,e]	zero events in both groups
Adverse events - not reported	-	-	-	-	-	outcome not yet measured or reported
Serious adverse events D14-D28	400 per 1.000	**400 per 1.000** (136 to 1.000)	**RR 1.00** (0.34 to 2.93)	20 (1 RCT)	⊕⊕◯◯ LOW [d,f,g]	

***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviations from intended interventions and selection of the reported results; b. Indirectness downgraded by 1 level: single study from a single institution, therefore results in this population might not be generalizable to other settings; c. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants; d. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviations from intended interventions, measurement of the outcome and selection of the reported results; e. Imprecision downgraded by 2 levels: no events in both groups and very low number of participants; f. Indirectness not downgraded: we presume that adverse event rate is not specific to a certain setting; g. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants

*Table 3.3-4: Summary of findings table on **favipiravir compared to standard care** (6 RCTs: Lou 2020, Ivashchenko 2020, Dabbous 2020, Balykova 2020, Ruzhentsova 2020, Udwadia 2020) - https://covid-nma.com/living_data/index.php*

Favipiravir compared to Standard care for Mild/Moderate/Unclear COVID-19

Patient or population: Mild/Moderate/Unclear COVID-19
Setting: Worldwide
Intervention: Favipiravir
Comparison: Standard care

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard care	Risk with Favipiravir				
Viral negative conversion D7	668 per 1,000	**735 per 1,000** (641 to 848)	**RR 1.10** (0.96 to 1.27)	696 (6 RCTs) [b]	⨁⨁◯◯ LOW [c,d]	
Clinical improvement D28	552 per 1,000	**563 per 1,000** (524 to 601)	**RR 1.02** (0.95 to 1.09)	579 (5 RCTs) [e]	⨁⨁◯◯ LOW [f,g]	
Clinical improvement D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above) D28	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	370 (3 RCTs) [h]	⨁◯◯◯ VERY LOW [i,j]	zero events in both groups
WHO progression score (level 7 or above) D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D28	9 per 1,000	**3 per 1,000** (0 to 27)	**RR 0.33** (0.04 to 3.16)	470 (4 RCTs) [k]	⨁◯◯◯ VERY LOW [i,j]	
All-cause mortality D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
Adverse events	287 per 1,000	**442 per 1,000** (250 to 789)	**RR 1.54** (0.87 to 2.75)	578 (4 RCTs) [m]	⨁◯◯◯ VERY LOW [n,o,p]	
Serious adverse events	21 per 1,000	**25 per 1,000** (10 to 62)	**RR 1.20** (0.48 to 3.00)	538 (4 RCTs) [q]	⨁◯◯◯ VERY LOW [i,n]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).CI: Confidence interval; RR: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect. Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different:Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect:Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last update: March 2, 2021; b. Balykova L, 2020; Dabbous HM, 2020; Ivashchenko AA, 2020; Lou Y, 2020; Ruzhentsova T, 2020; Udwadia Z, 2020; c. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviation from intended intervention and selection of reported results; d. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect; e. Ivashchenko AA, 2020; Lou Y, 2020; Ruzhentsova TA, 2020; Udwadia Z, 2020, Balykova L, 2020; f. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviation from intended intervention, outcome measurement and selection of reported results; g. Imprecision downgraded by 1 level: due to low number of events and/or participants; h. Balykova L, 2020; Lou Y, 2020, Udiwadia Z, 2020; i. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization and deviation from intended intervention; j. Imprecision downgraded by 2 levels: no events in both groups and low number of participants; k. Balykova L, 2020; Lou Y, 2020; Dabbous HM, 2020; Udwadia Z, 2020; l. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants; m. Balykova L, 2020; Ivashchenko AA, 2020; Ruzhentsova T, 2020; Udwadia Z, 2020; n. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviations from intended intervention and outcome measurement; o. Inconsistency downgraded by 1 level: I^2=79.6%; p. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for no effect and the possibility for harm; q. Balykova L, 2020; Lou Y, 2020; Ruzhentsova T, 2020; Udwadia Z, 2020

3.4 Darunavir

About the drug under consideration

antivirales Medikament

Darunavir is an antiviral agent from the group of human immunodeficiency virus (HIV) protease inhibitors for the treatment of HIV-1 infections. Darunavir is combined with a pharmacokinetic booster such as ritonavir or cobicistat [108].

als HIV Medikament zugelassen EMA 2007

Darunavir (Prezista®) has not been approved by the European Medicines Agency (EMA) or the American Food and Drug Administration (FDA) for COVID-19.

Empfehlungen des US COVID-19 Treatment Guidelines Panel GEGEN jegliche HIV Protease Inhibitoren

The US COVID-19 Treatment Guidelines Panel recommends **against** using the **Lopinavir/ritonavir (AI) or other HIV protease inhibitors (AIII),** except in a clinical trial, because of unfavorable pharmacodynamics and because clinical trials have not demonstrated a clinical benefit in patients with COVID-19 [86].

Withdrawn, suspended or terminated studies

keine weiteren Studien in ClinicalTrials.gov and EudraCT als abgeschlossen oder beendet registriert

The search in two clinical trial registers (ClinicalTrials.gov and EUdraCT) yielded no suspended, withdrawn or terminated RCTs in COVID-19.

Results of publications

Publikation zu RCT bei milder Covid-19 Erkrankung DRV+IFN vs. IFN kein Unterschied

Chen J et al. 2020 [109] published results from single-center, randomized, open-label trial (**NCT04252274**) which aimed to evaluate the antiviral activity and safety of darunavir/cobicistat (DRV/c) in treating mild COVID-19 patients. Participants were randomized to receive DRV/c for 5 days on the top of interferon alpha 2b inhaling or interferon alpha 2b inhaling alone. DRV/c did not increase the proportion of negative conversion vs standard of care alone: the proportion of negative PCR results at day 7 was 46.7% (7/15) and 60.0% (9/15) in the DRV/c and control groups (p=0.72), respectively. The viral clearance rate at day 3 was 20% (3/15) in both study groups, while the number increased to 26.7% (4/15) in the DRV/c group and remained 20% (3/15) in the control group at day 5. Fourteen days after randomization, 1 participant in the DRV/c group progressed to critical illness and discontinued DRV/c, while all the patients in the control group were stable (p=1.0). The frequencies of adverse events in the two groups were comparable. The findings are presented in Table 3.4-1.

*Table 3.4-1: Summary of findings table on **darunavir/cobicistat compared to standard care** (1 RCT: Chen J) - https://covid-nma.com/living_data/index.php [109]*

Darunavir/cobistat compared to Standard Care for Moderate COVID-19

Patient or population: Moderate COVID-19
Setting: Worldwide
Intervention: Darunavir/cobistat
Comparison: Standard Care

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care	Risk with Darunavir/cobicistat				
Incidence of viral negative conversion D7	600 per 1.000	**468 per 1.000** (234 to 924)	**RR 0.78** (0.39 to 1.54)	30 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,c]	
Clinical improvement - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical recovery - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 6 or above) - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above D7)	0 per 1.000	**0 per 1.000** (0 to 0)	**RR 3.00** (0.13 to 68.26)	30 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,d]	zero events in control group
All-cause mortality D14-D28				30 (1 RCT)	⊕◯◯◯ VERY LOW [a,b,e]	zero events in both groups
Adverse events - not reported	-	-	-	-	-	outcome not yet measured or reported
Serious adverse events D14-D28				30 (1 RCT)	⊕◯◯◯ VERY LOW [e,f,g]	zero events in both groups

***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Risk of bias downgraded by 1 level: some concerns or high risk due to concerns during the randomization process, deviations from intended interventions and selection of the reported results; b. Indirectness downgraded by 1 level: single study from a single institution, therefore results in this population might not be generalizable to other settings; c. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants; d. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants e. Imprecision downgraded by 2 levels: no events in both groups and very low number of participants; f. Risk of bias downgraded by 2 levels: some concerns or high risk due to concerns during the randomization process, deviation from intended intervention, missing data and selection of reported results; g. We presume that the adverse event rates, and the corresponding relative risks, is similar across diverse settings, therefore not downgraded for indirectness

3.5 Chloroquine (Resochin®) and

3.6 Hydroxychloroquine (Plaquenil®)

Due to the lack of effectiveness of chloroquine and hydroxychloroquine in treating COVID-19 patients; in the light of serious adverse effects as well as the decisions to stop enrolling participants to the hydroxychloroquine arm of the RECOVERY and SOLIDARITY trials, the reporting related to these two pharmaceuticals was stopped also.

wegen erwiesenem Mangel an Wirksamkeit wurde Beobachtung beendet

Last reporting V4/ July:
https://eprints.aihta.at/1234/10/Policy_Brief_002_Update_07.2020.pdf

3.7 Camostat Mesilate (Foipan®)

About the drug under consideration

Camostat Mesilate (Foipan®) is classified as a so-called serine protease inhibitor, blocking several pancreatic and plasmatic enzymes like trypsin, thrombin and plasmin [110]. Studies showed effects on the cell-entry mechanism of coronaviruses (e.g. SARS-CoV and SARS-CoV-2) in in-vitro human cells [111, 112] as well as in pathogenic mice-models [113] by inhibiting the enzyme Transmembrane protease, serine 2 (TMPRSS2).

Protease-Inhibitor bei Entzündung der Bauchspeicheldrüse
Zulassung: Japan, Süd-Korea

Camostat Mesilate (Foipan®) ist not approved for any anti-viral use (FDA, EMA).

nicht EMA, FDA
FDA: Orphan Drug Designation seit 2011

It is one of the drugs for which the German Federal Ministry of Health initiated centralized procurement in April 2020 for the treatment of infected and seriously ill COVID-19 patients in Germany (https://www.abda.de). Up to August 1, 2020, 35 to 60 Covid-19 patients have been treated with the centrally procured medicinal product Foipan (Camostat) as part of an individual medical treatment. There was no obligation for the treating physicians to collect data in a registry [114].

vom dt. BMG für schwere Erkrankungen zentral eingekauft

Withdrawn, suspended or terminated studies

One withdrawn RCT was found (NCT04338906) related to combination therapy camostat + hydroxychloroquine because hydroxychloroquine not being standard of care anymore); no suspended or terminated studies were found in ClinicalTrials.gov and EUdraCT registers.

in ClinicalTrials.gov and EUdraCT keine abgeschlossenen klinischen Studien registriert

Results of publications

Until now no scientific publication on a RCT of Camostat Mesilate (Foipan®) in Covid-19 patients could be identified.

3.8 APN01/ Recombinant Human Angiotensin-converting Enzyme 2 (rhACE2)

Drug under consideration

APN01 is a recombinant human Angiotensin Converting Enzyme 2 (rhACE2) developed by Apeiron Biologics under Phase 2 clinical development in ALI (Acute Lung Injury) and PAH (Pulmonal arterial hypertension) [115], [116], [117].

aus SARS-Forschung hervorgegangen

The therapy with APN01 is currently not approved by the European Medicine Agency (EMA) and Food and Drug Administraion (FDA) for COVID-19.

keine Zulassung
1 Studie (Phase 2 RCT), vor Rekrutierung

Withdrawn, suspended or terminated studies

One RCT number NCT04287686 is visible as withdrawn (without CDE Approval).

in ClinicalTrials.gov and EUdraCT keine abgeschlossene, aber eine zurückgezogene Studie registriert

Results of publications

No relevant finished publications or finished trials assessing the efficacy and safety could be identified. First results, related to a phase 2/3 study of hrsACE2 in 200 hospitalised patients with COVID-19, with primary composite outcome – All-cause mortality or invasive mechanical ventilation can be expected on the 10th of November 2020 (NCT04335136) [118].

keine Publikationen zu klinischen Studien

3.9 Tocilizumab (Roactemra®)

Drug under consideration

Tocilizumab (*RoActemra*) is a human monoclonal antibody that specifically binds to soluble and membrane-bound interleukin (IL)-6 receptors (IL-6Rα), and inhibits IL-6-mediated signalling [119].

Interleukin-6-Rezeptor für rheumatoide Arthritis zugelassen (EMA)

Tocilizumab is being investigated as a possible treatment for patients with moderate to severe or critical COVID-19. The therapy is currently not approved by the European Medicine Agency (EMA) and Food and Drug Administraion (FDA) for COVID-19.

The **US COVID-19 Treatment Guidelines Panel** Statement (**March 5, 2021**) [86]

US COVID-19 Treatment Guidelines Panel

- The Panel recommends the use of **tocilizumab** (single intravenous dose of 8 mg/kg of actual body weight, up to 800 mg) **in combination with dexamethasone** (6 mg daily for up to 10 days) in certain hospitalised patients who are exhibiting rapid respiratory decompensation due to COVID-19. The patients included in this population are:
  - Recently hospitalised patients who have been admitted to the intensive care unit (ICU) within the prior 24 hours and who require invasive mechanical ventilation, noninvasive mechanical ventilation (NIV), or high-flow nasal canula (HFNC) oxygen (>0.4 FiO_2/30 L/min of oxygen flow) **(BIIa)**; **or**

ICU-Patient*innen mit invasiver Beatmung:

in Kombination mit Dexamethasone

  - Recently hospitalised patients (not in the ICU) with rapidly increasing oxygen needs who require NIV or HFNC and have significantly increased markers of inflammation **(BIIa)** (**Note**: The RECOVERY trial inclusion criterion for inflammation was C-reactive protein [CRP] ≥75 mg/L).
- For hospitalised patients with hypoxemia who require conventional oxygen supplementation, the Panel recommends using one of the following options: **remdesivir (BIIa)**, **dexamethasone plus remdesivir (BIII)**, or **dexamethasone alone (BI).**
  - There is insufficient evidence to specify which of these patients would benefit from the addition of tocilizumab. Some Panel members would also give tocilizumab to patients who are exhibiting rapidly increasing oxygen needs while on dexamethasone and have a CRP ≥75 mg/L but who do not yet require NIV or HFNC, as described above.

Withdrawn, suspended or terminated studies

1 beendeter RCT, 1 zurückgezogener (admin Gründe), 1 abgebrochener (Mangel an Rekrutierung)

One withdrawn RCT (NCT04361552, in US, abandoned due to drug billing issues) and four terminated RCTs were found in ClinicalTrials.gov and EudraCT registers: NCT04346355, in Italy, based on interim analysis for futility and given an enrolment rate almost nil; RCT on 129 patients in Brazil compared tocilizumab vs best supportive care NCT04403685 (TOCIBRAS) due to safety issue; RCT NCT04322773, TOCIVID trial, due to changed clinical conditions and too few patients available; RCT NCT04335071 (CORON-ACT) in Switzerland because dexamethasone was included in the standard care and planned number of patients was not possible to recruit in the planned study period).

Results of publications

COVACTA
4RCT, 52 Pts
schwere Erkrankung

kein Unterschied bei Mortalität, aber kürzer Zeit zur Erholung

Rosas et al. 2020 [120] reported results from the phase 3, RCT - **COVACTA** (**NCT04320615, EUdraCT 2020-001154-22**) as preprint: 452 patients with **severe COVID-19 pneumonia** were randomized; the modified-intention-to-treat population included 294 tocilizumab-treated and 144 placebo-treated patients. Clinical status at day 28 was not statistically significantly improved for tocilizumab versus placebo (p=0.36). Median (95% CI) ordinal scale values at day 28: 1.0 (1.0 to 1.0) for tocilizumab and 2.0 (1.0 to 4.0) for placebo (odds ratio, 1.19 [0.81 to 1.76]). There was no difference in mortality at day 28 between tocilizumab (19.7%) and placebo (19.4%) (difference, 0.3% [95% CI, –7.6 to 8.2]; nominal p=0.94). Median time to hospital discharge was 8 days shorter with tocilizumab than placebo (20.0 and 28.0, respectively; nominal p=0.037; hazard ratio 1.35 [95% CI 1.02 to 1.79]). Median duration of ICU stay was 5.8 days shorter with tocilizumab than placebo (9.8 and 15.5, respectively; nominal p=0.045). In the safety population, serious adverse events occurred in 34.9% of 295 patients in the tocilizumab arm and 38.5% of 143 in the placebo arm.

Wang (China)
65 Pts
schwere Erkrankung

Wang et al. 2020 [121] reported, as preprint, results from a small randomized, controlled, open-label, multicenter trial at 6 hospitals in Anhui and Hubei (**ChiCTR2000029765**). 65 **moderate to severe COVID-19 patients** were enrolled and randomly assigned to a treatment group (33 to tocilizumab and 32 to the controls). The cure rate in tocilizumab group was higher than that in the controls but not significant (94.12% vs 87.10%, p=0.4133). Adverse events were recorded in 20 (58.82%) of 34 tocilizumab recipients versus 4

(12.90%) of 31 in the controls. No serious adverse events were reported in tocilizumab group.

Salama et al. 2020 [122], reported as preprint, results from the phase III **EMPACTA** study (**NCT04372186**) (389 patients in the United States, South Africa, Kenya, Brazil, Mexico and Peru), showing that patients with **COVID-19 associated pneumonia** who received tocilizumab plus standard of care were 44% less likely to progress to mechanical ventilation or death compared to patients who received placebo plus standard of care (log-rank p-value = 0.0348; HR [95% CI] = 0.56 [0.32, 0.97]). The cumulative proportion of patients who progressed to mechanical ventilation or death by day 28 was 12.2% in tocilizumab arm versus 19.3% in the placebo arm. Key secondary outcomes (difference in time to hospital discharge or "ready for discharge" to day 28; difference in time to improvement in ordinal clinical status to day 28; time to clinical failure to day 28 and mortality by day 28) were not statisticaly significant different between groups. At day 28, incidence of infections was 10% and 11% in the tocilizumab and placebo arms, respectively, and the incidence of serious infections was 5.0% and 6.3% in tocilizumab and placebo arms, respectively. The most common adverse events in patients who received tocilizumab were constipation (5.6%), anxiety (5.2%), and headache (3.2%).

EMPACTA
389 Pts
RCT (US, SA,Kenya, Brasilien, Mexiko, Peru)
schwere Erkrankung

Vorteil bei Verhinderung im Fortschreiten der Erkrankung

bei weiteren Endpunkten: kein Unterschied

Hermine et al. 2020 [123] published the results from multicentre **CORIMUNO-TOCI-1** RCT (**NCT04331808**), which included 131 **moderate to severe COVID-19** patients (63 treated with tocilizumab, others in usual care group) in France, with follow-up through 28 days. In the TCZ group, 12 patients had a WHO-CPS score greater than 5 at day 4 vs 19 in the UC group (median posterior absolute risk difference [ARD] -9.0%; 90% credible interval [CrI], -21.0 to 3.1), with a posterior probability of negative ARD of 89.0% not achieving the 95% predefined efficacy threshold. At day 14, 12% (95% CI -28% to 4%) fewer patients needed noninvasive ventilation (NIV) or mechanical ventilation (MV) or died in the TCZ group than in the UC group (24% vs 36%, median posterior hazard ratio [HR] 0.58; 90% CrI, 0.33-1.00), with a posterior probability of HR less than 1 of 95.0%, achieving the predefined efficacy threshold. The HR for MV or death was 0.58 (90% CrI, 0.30 to 1.09). At day 28, 7 patients had died in the TCZ group and 8 in the UC group (adjusted HR, 0.92; 95% CI 0.33-2.53). Serious adverse events occurred in 20 (32%) patients in the TCZ group and 29 (43%) in the UC group (p=0.21).

CORIMUNO-TOCI-1
131 Pts.
moderate bis schwere Erkrankung

Vorteil bei Bedarf nach Beatmung
kein Unterschied bei Mortalität

Salvarani et al. 2020 [124] published results from multicentre RCT **(RCT-TCZ-COVID-19) (NCT04346355)** conducted on 126 **severe COVID-19 patients** in Italy (60 received tocilizumab). Seventeen patients of 60 (28.3%) in the tocilizumab arm and 17 of 63 (27.0%) in the standard care group showed clinical worsening within 14 days since randomization (rate ratio, 1.05; 95% CI, 0.59-1.86). Two patients in the experimental group and 1 in the control group died before 30 days from randomization, and 6 and 5 patients were intubated in the 2 groups, respectively. The trial was prematurely interrupted after an interim analysis for futility.

RCT-TCZ-COVID-19
126 Pts
schwere Erkrankung

kein Unterscheid, frühzeitiger Studienabbruch

Stone et al. 2020 [125] published results from multicentre RCT **(NCT04356937)** conducted on 243 **moderate to severe COVID-19 patients** in US (161 received tocilizumab). The hazard ratio for intubation or death in the tocilizumab group vs placebo group was 0.83 (95% confidence interval [CI], 0.38 to 1.81; p=0.64), and the hazard ratio for disease worsening was 1.11 (95% CI, 0.59 to 2.10; p=0.73). At 14 days, 18.0% of the patients in the

RCT 243
moderate bis schwere Erkrankung

keine oder klaum Unterschiede in einigen Endpunkten

tocilizumab group and 14.9% of the patients in the placebo group had worsening of disease. The median time to discontinuation of supplemental oxygen was 5.0 days (95% CI, 3.8 to 7.6) in the tocilizumab group vs 4.9 days (95% CI, 3.8 to 7.8) in the placebo group (p=0.69). At 14 days, 24.6% of the patients in the tocilizumab group and 21.2% of the patients in the placebo group were still receiving supplemental oxygen. Patients who received tocilizumab had fewer serious infections than patients who received placebo.

REMAP-CAP Studienarm
353 Pts

Vorteile bei 90-Tages Überleben,
Zeit bis zur Intensivmedizin
Spitalsentlassung
klinische Verbesserung

Gordon et al. 2021 [126] published **preliminary report** as preprint, with **positive results** related to IL-6 receptor antagonist, **tocilizumab** and **sarilumab**, to improve outcome, including survival, in **critical COVID-19 patients**. This is ongoing international, multifactorial, adaptive platform trial (**REMAP-CAP, NCT02735707**), in which adult patients with criticall Covid-19, within 24 hours of commencing organ support in an intensive care unit, were randomized to receive either tocilizumab (8mg/kg) or sarilumab (400mg) or standard care (control). At the time of full analysis **353 patients** had been assigned to **tocilizumab**, **48 to sarilumab** and **402 to control**. Median organ support-free days were 10 (interquartile range [IQR] -1, 16), 11 (IQR 0, 16) and 0 (IQR -1, 15) for tocilizumab, sarilumab and control, respectively. Relative to control, median adjusted odds ratios were 1.64 (95% credible intervals [CrI] 1.25, 2.14) for tocilizumab and 1.76 (95%CrI 1.17, 2.91) for sarilumab, yielding >99.9% and 99.5% posterior probabilities of superiority compared with control. Hospital mortality was 28.0% (98/350) for tocilizumab, 22.2% (10/45) for sarilumab and 35.8% (142/397) for control. Tocilizumab and sarilumab were effective across all secondary outcomes, including 90-day survival, time to ICU and hospital discharge, and improvement in the World Health Organization (WHO) ordinal scale at day 14. There were nine serious adverse events reported in the tocilizumab group including one secondary bacterial infection, five bleeds, two cardiac events and one deterioration in vision. There were 11 serious adverse events in the control group, four bleeds and seven thromboses; and no serious adverse events in the sarilumab group.

RCT (Brasilien)
129 Patient*innen
schwere/ kritische Erkrankung

kein Unterschied bei klinischer Verbesserung
ev. sogar erhöhte Mortalität

Veiga et al. 2021 [127] published results from RCT conducted in Brazil, in severe or critical COVID-19 (**NCT04403685**). The data monitoring committee recommended stopping the trial early, after 129 patients had been enrolled, because of an increased number of deaths at 15 days in the tocilizumab group. A total of 129 patients were enrolled and all completed follow-up. All patients in the tocilizumab group and two in the standard care group received tocilizumab. 18 of 65 (28%) patients in the tocilizumab group and 13 of 64 (20%) in the standard care group were receiving mechanical ventilation or died at day 15 (odds ratio 1.54, 95% confidence interval 0.66 to 3.66; p=0.32). Death at 15 days occurred in 11 (17%) patients in the tocilizumab group compared with 2 (3%) in the standard care group (odds ratio 6.42, 95% confidence interval 1.59 to 43.2). Adverse events were reported in 29 of 67 (43%) patients who received tocilizumab and 21 of 62 (34%) who did not receive tocilizumab. Authors concluded that in patients with severe or critical covid-19, tocilizumab plus standard care was not superior to standard care alone in improving clinical outcomes at 15 days, and it might increase mortality.

Tocilizumab auch in RECOVERY

On **February 11, 2021 RECOVERY Collaborative Group** published as preprint **preliminary results** from **RECOVERY trial (ISRCTN 50189673, NCT04381936)** [128] [129]. Participants with hypoxia (oxygen saturation <92% on air or requiring oxygen therapy) and evidence of systemic inflammation (C-reactive protein [CRP] ≥75 mg/L) were eligible for randomisation to usual standard of care alone versus usual standard of care plus tocilizumab at a dose of 400 mg to 800 mg (depending on weight) given intravenously. A second dose could be given 12 to 24 hours later if the patient's condition had not improved. The primary outcome was 28-day mortality, assessed in the intention-to-treat population. **4116 adults were included** in the assessment of tocilizumab, including 562 (**14%**) patients receiving **invasive mechanical ventilation**, 1686 (**41%**) receiving **non-invasive respiratory support**, and 1868 (**45%**) receiving no respiratory support other than **oxygen**. 3385 (82%) patients were receiving systemic corticosteroids at randomisation. Overall, 596 (29%) of the 2022 patients allocated tocilizumab and 694 (33%) of the 2094 patients allocated to usual care died within 28 days (rate ratio 0.86; 95% confidence interval [CI] 0.77-0.96; p=0.007). Consistent results were seen in all pre-specified subgroups of patients. In particular, a clear mortality benefit was seen in those receiving systemic corticosteroids. Patients allocated to tocilizumab were more likely to be discharged from hospital alive within 28 days (54% vs. 47%; rate ratio 1.22; 95% CI 1.12- 1.34; p<0.0001).

4.116 Patient*innen in RCT : invasiv und nicht-invasiv beatmete

davon 2.022 mit Tocilizumab
29% in Tocilizumab
33% in SoC verstarben

höhere Wahrscheinlichkeit, innerhalb von 28 Tagen aus Spital entlassen zu werden

klarer Überlebensvorteil mit Kortikosteroiden (+ Tocilizumab)

Among those **not receiving invasive mechanical ventilation** at baseline, patients allocated tocilizumab were less likely to reach the composite endpoint of invasive mechanical ventilation or death (33% vs. 38%; risk ratio 0.85; 95% CI 0.78-0.93; p=0.0005). Authors concluded that tocilizumab improved survival and other clinical outcomes. These benefits were seen regardless of the level of respiratory support and were additional to the benefits of systemic corticosteroids.

nicht beatmete Patient*innen: geringere Wahrscheinlichkeit von Nutzen

Soin et al. 2021 [130] published results from phase 3 RCT (**COVINTOC**) (CTRI/2020/05/025369) conducted on **moderate to severe COVID-19** patients in India. 180 patients were randomly assigned to the tocilizumab group (n=90) or the standard care group (n=90). 75 (82%) of 91 in the tocilizumab group and 68 (76%) of 89 in the standard care group completed 28 days of follow-up. Progression of COVID-19 up to day 14 occurred in eight (9%) of 91 patients in the tocilizumab group and 11 (13%) of 88 in the standard care group (difference –3.71 [95% CI –18.23 to 11.19]; p=0.42). 33 (36%) of 91 patients in the tocilizumab group and 22 (25%) of 89 patients in the standard care group had adverse events; 18 (20%) and 15 (17%) had serious adverse events. The most common adverse event was acute respiratory distress syndrome, reported in seven (8%) patients in each group. Grade 3 adverse events were reported in two (2%) patients in the tocilizumab group and five (6%) patients in the standard care group. There were no grade 4 adverse events. Serious adverse events were reported in 18 (20%) patients in the tocilizumab group and 15 (17%) in the standard care group; 13 (14%) and 15 (17%) patients died during the study. Among the subset of patients who had severe COVID-19 at baseline, the proportions of patients who had disease progression (ie, died) up to day 28 were 16% (eight of 50) in the tocilizumab group and 34% (14 of 41) in the standard care group, with a difference of –18.15 (–37.79 to 2.43; p=0.044). The median time to disease progression or death to day 28 was not reached (ie, not evaluable; data for 37 patients who did not complete 28 days of follow-up and two patients who died after day 28 were censored at day 28) in the post-hoc analysis of all patients or of those with severe COVID-19 at baseline. The log-rank p values for between-group comparisons were 0.25 overall and 0.04 for those with severe disease.

Analyse basierend auf 3 RCTs
180 Patient*innen

moderat bis schwer Erkrankte

kaum Unterschiede

Meta-analysis with Summary of findings table on tocilizumab compared to standard of care (related to **10 RCTs**) is presented in Table 3.9-1. According to currently available scientific evidence, tocilizumab compared to standard care/placebo reduces All-cause mortality D28 (RR 0.89, 95% CI 0.82 to 0.97, 9 RCTs, high certainty of evidence); probably does not increase incidence of Serious adverse events (RR 0.91, 95% CI 0.77 to 1.08, 9 RCTs, moderate certainty of evidence); probably increases Clinical improvement D28 (RR 1.06, 95% CI 1.00 to 1.13, 7 RCTs, moderate certainty of evidence). Does tocilizumab reduces WHO progression score level 7 or above D28 is very uncertain (RR 0.99, 95% CI 0.56 to 1.74, 3 RCTs, very low certainty of evidence). The evidence is very uncertain about the effect of tocilizumab on outcome Adverse events (RR 1.23, 95% CI 0.93 to 1.62, 8 RCTs, very low certainty of evidence).

Metaanalyse von 10 RCTs: kleine Vorteil bei Gesamtüberleben kein Vorteil bei klinischen Verbesserungen

*Table 3.9-1: Summary of findings table on **tocilizumab compared standard care/placebo** (10 RCTs: Rosas, Wang, Hermine, Salvarani, Stone, Salama, Veiga, Gordon, RECOVERY-TCZ, Soin)*

Tocilizumab compared to Standard care/Placebo for Mild/Moderate/Severe/Critical COVID-19
Patient or population: Mild/Moderate/Severe/Critical COVID-19
Setting: Worldwide
Intervention: Tocilizumab
Comparison: Standard care/Placebo

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard care/Placebo	Risk with Tocilizumab				
Viral negative conversion D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement D28 [b]	515 per 1.000	**545 per 1.000** (515 to 581)	**RR 1.06** (1.00 to 1.13)	5585 (7 RCTs) [c]	⊕⊕⊕◯ MODERATE [d]	
Clinical improvement D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above) D28	262 per 1.000	**260 per 1.000** (147 to 457)	**RR 0.99** (0.56 to 1.74)	712 (3 RCTs) [e]	⊕◯◯◯ VERY LOW [f,g,h]	
WHO progression score (level 7 or above) D60 or - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D28	288 per 1.000	**256 per 1.000** (236 to 279)	**RR 0.89** (0.82 to 0.97)	6543 (9 RCTs) [i]	⊕⊕⊕⊕ HIGH [j]	
All-cause mortality D60 or above	133 per 1.000	**114 per 1.000** (70 to 186)	**RR 0.86** (0.53 to 1.40)	519 (2 RCTs) [k]	⊕⊕◯◯ LOW [f,l]	
Adverse events	429 per 1.000	**527 per 1.000** (399 to 695)	**RR 1.23** (0.93 to 1.62)	1714 (8 RCTs) [m]	⊕◯◯◯ VERY LOW [n,o,p]	
Serious adverse events	150 per 1.000	**137 per 1.000** (116 to 162)	**RR 0.91** (0.77 to 1.08)	2492 (9 RCTs) [q]	⊕⊕⊕◯ MODERATE [n]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; **RR**: Risk ratio; **HR**: Hazard Ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last update: 1 April, 2021; b. Clinical improvement was defined variably as an improvement from baseline in >2 categories on a 7-category ordinal scale (Rosas I, COVACTA, 2021); a decrease of at least 2 points on an ordinal clinical improvement scale (Stone JH, 2020); or hospital discharge or ready to discharge (Hermine O, CORIMUNO-19, 2020; Horby P, RECOVERY (TCZ), 2021; Salvarani C, 2020; Salama C, EMPACTA, 2020; Veiga VC, TOCIBRAS, 2021); c. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNO-19, 2020; Rosas I, COVACTA, 2021; Horby P, RECOVERY (TCZ), 2021; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020; d. Risk of bias downgraded by 1 level: some concerns due to deviation from intended interventions, outcome measurement and selection of reported results; e. Hermine O, CORIMUNO-19, 2020; Rosas I, COVACTA, 2021; Horby P, RECOVERY (TCZ), 2021; Veiga VC, TOCIBRAS, 2021; f. Despite some concerns due to deviation from intended intervention in two studies, risk of bias was not downgraded.; g. Inconsistency downgraded by 1 level: I^2=64.4%; h. Imprecision downgraded by 2 levels: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm; i. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNDO-19, 2020; Rosas I, COVACTA, 2021; Soin AS, COVINTOC, 2021; Horby P, RECOVERY, 2021; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020, Gordon AC, REMAP-CAP, 2021; j. Despite some concerns due to deviation from intended interventions, risk of bias was not downgraded because the studies at risk contributed < 20% weight to the effect estimate.; k. Hermine O, CORIMUNO-19, 2020; Salama C, EMPACTA, 2020; l. Imprecision downgraded by 2 levels: due to low number of events and a wide confidence interval consistent with the possibility for benefit and the possibility for harm; m. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNO-19, 2020; Wang D, 2020; Rosas I, COVACTA, 2021; Soin AS, COVINTOC, 2021; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020; n. Risk of bias downgraded by 1 level: some concerns regarding randomization, deviations from intend; d interventions, outcome measurement and selection of reported result; o. Inconsistency downgraded by 1 level: I^2=81.3%; p. Imprecision downgraded by 1 level: due to a wide confidence interval consistent with the possibility for no effect and the possibility for harm; q. Salama C, EMPACTA, 2020; Stone JH, 2020; Hermine O, CORIMUNO-19, 2020; Wang D, 2020; Rosas I, COVACTA, 2021; Soin AS, COVINTOC, 2021; Veiga VC, TOCIBRAS, 2021; Salvarani C, 2020, Gordon AC, REMAP-CAP, 2021

3.10 Sarilumab (Kevzara®)

Drug under consideration

Sarilumab (*Kevzara*) is a human monoclonal antibody that specifically binds to soluble and membrane-bound interleukin (IL)-6 receptors (IL-6Rα), and inhibits IL-6-mediated signalling [131]. It is being investigated as a possible treatment for patients with moderate to severe or critical COVID-19. The therapy is currently not approved by the European Medicine Agency (EMA) and Food and Drug Administraion (FDA) for COVID-19.

Interleukin-6-Rezeptor für rheumatoide Arthritis zugelassen (EMA)

Covid-10: bei erhöhten IL-6-Spiegeln

Withdrawn, suspended or terminated studies

One RCT found as suspended, NCT04341870 - CORIMUNO-VIRO Trial (DSMB recommendation (futility)). One RCT found as terminated, NCT04322773 (TOCIVID) in Denmark, due to changed clinical conditions and too few patients available).

Results of publications

Juli 2020: Pressemeldung zu RCT mit 194 Pts

kein Unterschied mehr SAE in Sarilumab Gruppe

Publikation der Ergebnisse März 2021:

keine Unterschiede, negative Ergebnisse

On July 03, 2020 in press release related to sarilumab RCT conducted in US, https://www.clinicaltrialsarena.com/news/kevzara-us-covid19-trial-data/, Sanofi and Regeneron Pharmaceuticals have reported that this phase III clinical trial of sarilumab, compared 400mg dose of the drug plus best supportive care to best supportive care alone, failed to meet its primary and key secondary endpoints in 194 **critically ill Covid-19 patients** who required mechanical ventilation in the US. In the primary analysis arm, adverse events were reported in 80% of patients treated with sarilumab and 77% of those on placebo. Serious adverse events in at least 3% of patients, more frequent among sarilumab patients, were multi-organ dysfunction syndrome and hypotension. Based on the data, the companies have halted this US-based trial, including a second cohort of patients who were on a higher 800mg dose of the drug. The trial being conducted outside of the US was continuing, in hospitalised patients with severe and critical Covid-19 using a different dosing regimen, with published **negative results** in March 2021 by Lescure et al. (NCT04327388, EudraCT 2020-001162-12)[132] 420 patients were randomly assigned and 416 received placebo (n=84 [20%]), sarilumab 200 mg (n=159 [38%]), or sarilumab 400 mg (n=173 [42%]). At day 29, no significant differences were seen in median time to an improvement of two or more points between placebo (12·0 days [95% CI 9·0 to 15·0]) and sarilumab 200 mg (10·0 days [9·0 to 12·0]; hazard ratio [HR] 1·03 [95% CI 0·75 to 1·40]; log-rank p=0·96) or sarilumab 400 mg (10·0 days [9·0 to 13·0]; HR 1·14 [95% CI 0·84 to 1·54]; log-rank p=0·34), or in proportions of patients alive (77 [92%] of 84 patients in the placebo group; 143 [90%] of 159 patients in the sarilumab 200 mg group; difference −1·7 [−9·3 to 5·8]; p=0·63 *vs* placebo; and 159 [92%] of 173 patients in the sarilumab 400 mg group; difference 0·2 [−6·9 to 7·4]; p=0·85 *vs* placebo). At day 29, there were numerical, non-significant survival differences between sarilumab 400 mg (88%) and placebo (79%; difference +8·9% [95% CI −7·7 to 25·5]; p=0·25) for patients who had critical disease. No unexpected safety signals were seen. The rates of treatment-emergent adverse events were 65% (55 of 84) in the placebo group, 65% (103 of 159) in the sarilumab 200 mg group, and 70% (121 of 173) in the sarilumab 400 mg group, and of those leading to death 11% (nine of 84) were in the placebo group, 11% (17 of 159) were in the sarilumab 200 mg group, and 10% (18 of 173) were in the sarilumab 400 mg group.

REMAP-CAP Studienarm 48 Pts.

Vorteile bei Soitalsmortalität, 90-Tages Überleben, Zeit bis zur Intensivmedizin Spitalsentlassung klinische Verbesserung

As already described in Tocilizumab Section above, Gordon et al. 2021 [126](REMAP-CAP, NCT02735707) published preliminary report as preprint, with positive results related to IL-6 receptor antagonist, tocilizumab and sarilumab, to improve outcome, including survival, in critical COVID-19 patients who were randomised to receive either tocilizumab (8mg/kg) or sarilumab (400mg) or standard care (control). At the time of full analysis 353 patients had been assigned to tocilizumab, 48 to sarilumab and 402 to control. Median organ support-free days were 11 (IQR 0, 16) sarilumab and and 0 (IQR -1, 15) for control. Relative to control, median adjusted odds ratio was 1.76 (95%CrI 1.17, 2.91) for sarilumab, compared with control. Hospital mortality was 22.2% (10/45) for sarilumab and 35.8% (142/397) for control. All secondary outcomes and analyses supported efficacy of these IL-6 receptor antagonists. There were no serious adverse events in the sarilumab group.

Zusammenfassung von 2 RCTs: kein Unterschied

Summary of finding table 3.10-1. related to these two RCTs mentioned above can be found below. In summary, sarilumab compared to standard care for severe/critical COVID-19 patients may not decrease All-cause mortality D28 (RR 0.77, 95% CI 0.43 to 1.36, 2 RCTs, low certainty of evidence) and may not increase SAEs (RR 1.17, 95% CI 0.77 to 1.77, 2 RCTs, low certainty of evidence). Sarilumab compared to standard care probably does not increase AEs (RR 1.05, 95% CI 0.88 to 1.25, 1 RCT, moderate certainty of evidence).

Table 3.10-1: Summary of findings table on ***Sarilumab compared to Standard Care for Severe/Critical COVID-19*** *(2 RCTs: Gordon REMAP-CAP, Lescure) –*

Sarilumab compared to Standard Care for Severe/Critical COVID-19

Patient or population: Severe/Critical COVID-19
Setting: Worldwide
Intervention: Sarilumab
Comparison: Standard Care

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	Nr of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care	Risk with Sarilumab				
All-cause mortality D28	299 per 1 000	**230 per 1 000** (129 to 407)	**RR 0.77** (0.43 to 1.36)	880 (2 RCTs) [b]	⨁⨁◯◯ LOW [c,d]	
All-cause mortality D60 or above	105 per 1 000	**105 per 1 000** (52 to 209)	**RR 1.0** (0.5 to 2.0)	420 (1 RCT) [e]	⨁⨁◯◯ LOW [e,f]	
Adverse events	640 per 1 000	**672 per 1 000** (563 to 799)	**RR 1.05** (0.88 to 1.25)	420 (1 RCT) [e]	⨁⨁⨁◯ MODERATE [g,h]	
Serious adverse events	62 per 1 000	**73 per 1 000** (48 to 110)	**RR 1.17** (0.77 to 1.77)	880 (2 RCTs) [b]	⨁⨁◯◯ LOW [d,g]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio; HR: Hazard Ratio

GRADE Working Group grades of evidence High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last updated: 12 February, 2021; b. Lescure FX, 2021; Gordon AC, REMAP-CAP, 2021; c. Despite some concerns due to deviation from intended interventions, we did not downgrade for risk of bias; d. Imprecision downgraded by 2 levels: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and few events; e. Lescure FX, 2021; f. Despite some concerns due to selection of the reported result, we did not downgrade for risk of bias; g. We presume that the adverse event rates and the corresponding relative risks, are similar across diverse settings; therefore not downgraded for indirectness.; h. Imprecision downgraded by 1 level: few events

3.11 Interferon beta 1a (SNG001) (Rebif®, Avonex®) and Interferon beta 1b (Betaferon®, Extavia®)

About the drug under consideration

Interferon beta-1a (INFb) is a cytokine in the interferon family used to treat relapsing multiple sclerosis (MS). Finding of studies in patients with MERS-CoV have led to exploration of treatment with INFb in COVID-19 [133].

INFb Präparate bei Multipler Sklerose zugelassen (EMA)

Two pharmaceuticals which the active substance Interferon beta-1a are commercially available: Rebif® and Avonex®. They are used to slow the progression of disability and reduce the number of relapses in MS. Rebif is approved by the European Medicines Agency (EMA) since 1998 and by the American Food and Drug Administration (FDA) since 2002. Avonex is approved by EMA since 1997 and by the FDA since 1996. Both drugs are approved for the treatment of relapsing forms of multiple sclerosis (MS), in cases of clinically isolated syndromes, as well as relapsing remitting disease, and active secondary progressive disease in adults.

Interferon beta-1a: Rebif® Avonex®
seit 1997/1998 zugelassen

nicht für Covid-19

Two pharmaceuticals, with the active substance Interferon beta-1b, are commercially available in EU: Betaferon® and Extavia® to treat adults with multiple sclerosis (MS) [134, 135]. Betaferon® is approved by the European Medicines Agency (EMA) since 1995. Extavia® is approved by EMA since 2008. Interferon beta-1a and beta-1b are not approved for COVID-19 patients treatment.

Interferon beta-1b: Betaferon® and Extavia®
seit 1995/2008 zugelassen
nicht für Covid-19

The US COVID-19 Treatment Guidelines Panel [86] **recommends against** use of the **interferons (alfa or beta)** for the treatment of **severely or critically ill** patients with COVID-19, except in the context of a clinical trial (AIII).

Empfehlung des US COVID-19 Treatment Guidelines Panel: nur in klinischen Studien

There are **insufficient data** for the Panel to recommend **either for or against** the use of the **Interferon-beta** for the treatment of early (i.e., <7 days from symptom onset) **mild and moderate** COVID-19.

Withdrawn, suspended or terminated studies

One RCT was found as suspended, NCT04469491 (COV-NI), on interferon beta 1b by nebulization in France (in anticipation for Data and Safety Monitoring Board).

Results of publications

The results from the first randomised controlled trial on triple combination of interferon beta-1b, lopinavir–ritonavir and ribavirin, in comparison with lopinavir–ritonavir (**NCT04276688**) are presented in Section 3.14 of this report [136].

Kombinationstherapie: Ergebnisse in 3.14

Results from **Huang et al. 2020** (**ChiCTR2000029387**) [137] related to Ribavirin Plus Interferon-Alpha, Lopinavir/Ritonavir Plus Interferon-Alpha, and Ribavirin Plus Lopinavir/Ritonavir Plus Interferon-Alpha in Patients With Mild to Moderate COVID-19 were presented in Section 3.14 of this report.

August 2020:
2 RCTs publiziert
1 RCT zu Kombinations-therapie in 3.14

Esquivel-Moynelo et al. 2020 [138] presented the results from a RCT for efficacy and safety evaluation of subcutaneous **IFN -α2b and IFNγ** administration in 79 patients positive to SARS-CoV-2. Patients were randomly assigned in a 1:1 ratio to receive either, subcutaneous treatment with a combination of 3.0 MIU IFN-α2b and 0.5 MIU IFN-γ, twice a week for two weeks, or thrice a week intramuscular injection of 3.0 MIU IFN-α2b. Additionally, all patients received lopinavir-ritonavir 200/50 mg every 12 h and chloroquine 250 mg every 12 h (standard of care). None of the patients developed severe COVID-19 during the study or the epidemiological follow-up for 21 more days.

1 RCT
79 Pts.
Kombinationstherapie IFN (unterscheidliche Dosierungen) + Kaletra

79 symptomatische/ asymptomatische Pts.

Monk et al. 2020 published results from randomised, double-blind, placebo-controlled, phase 2 pilot trial at nine UK sites (NCT04385095) [139]. 101 COVId-19 hospitalized adult patients were randomly assigned (1:1) to receive **inhaled nebulised interferon beta-1a** (SNG001) (6 MIU) or **placebo** by inhalation via a mouthpiece daily for 14 days. 66 (67%) patients required oxygen supplementation at baseline: 29 in the placebo group and 37 in the SNG001 group. Patients receiving SNG001 had greater odds of improvement on the OSCI scale (odds ratio 2·32 [95% CI 1·07–5·04]; p=0·033) on day 15 or 16 and were more likely than those receiving placebo to recover to an OSCI score of 1 (no limitation of activities) during treatment (hazard ratio 2·19 [95% CI 1·03–4·69]; p=0·043). No significant difference was found between treatment groups in the odds of hospital discharge by day 28: 39 (81%) of 48 patients had been discharged in the nebulised interferon beta-1a group compared with 36 (75%) of 48 in the placebo group (OR 1·84 [95% CI 0·64–5·29]; p=0·26). There was no significant difference between treatment groups in the odds of intubation or the time to intubation or death. SNG001 was well tolerated: the most frequently reported treatment-emergent adverse event was headache (seven [15%] patients in the SNG001 group and five [10%] in the placebo group). There were three deaths in the placebo group and none in the SNG001 group.

1 RCT
101 Pts
inhaltiertes INF

Vorteil bei klinischen Verbesserungen, nicht aber bei Dauer des Spitalsaufenthalts

Davoudi-Monfared et al. 2020 published results related to the RCT on **Interferon beta-1a** treatment (n=46) **vs** the **standard of care** (n=46), in 92 patients with severe COVID-19 in Iran **(IRCT20100228003449N28)** [140]. Finally 81 patients (42 in the IFN and 39 in the control group) completed the study. Time to the clinical response was not significantly different between the IFN and the control groups (9.7 +/- 5.8 vs. 8.3 +/- 4.9 days respectively, P=0.95). On day 14, 66.7% vs. 43.6% of patients in the IFN group and the control group were discharged, respectively (OR= 2.5; 95% CI: 1.05- 6.37). The 28-day overall mortality was significantly lower in the IFN then the control group (19% vs. 43.6% respectively, p= 0.015). Early administration significantly reduced mortality (OR=13.5; 95% CI: 1.5-118).

RCT (Iran)
92 Pts

Reduktion der 28-Tages Mortalität insb. bei früher Verabreichung von IFN

Rahmani et al. 2020 [141] published the results of RCT evaluated efficacy and safety of interferon (IFN) β-1b in the treatment of 80 patients with severe COVID-19 (**IRCT20100228003449N27**). Patients in the IFN group received **IFN β-1b** (250 mcg subcutaneously every other day for two consecutive weeks) along with the national protocol medications while in the **control** group, patients received only the **national protocol medications** (lopinavir/ritonavir or atazanavir/ritonavir plus hydroxychloroquine for 7–10 days). 33 patients in each group completed the study. Time to clinical improvment in the IFN group was significantly shorter than the control group ([9(6–10) vs. 11(9–15) days respectively, p = 0.002, HR = 2.30; 95% CI: 1.33–3.39]). At day 14, the percentage of discharged patients was 78.79% and 54.55% in the IFN and control groups respectively (OR = 3.09; 95% CI: 1.05–9.11, p = 0.03). ICU

RCT (Iran)
80 Pts
Zeit zur klinischen Verbesserung signifikant kürzer mit IFN, weniger ICU Einweisungen

nicht aber Dauer der Hospitalisierung und in ICU

admission rate in the control group was significantly higher than the IFN group (66.66% vs. 42.42%, p = 0.04). The duration of hospitalization and ICU stay were not significantly different between the groups. All-cause 28-day mortality was 6.06% and 18.18% in the IFN and control groups respectively (p = 0.12).

SOLIDARITY
651 Pts INF + lopinavir, 1.412 Pts. nur INF

keine Unterscheide bei den Endpunkten

In **SOLIDARITY (INF)** RCT (**ISRCTN83971151**) results on comparisons of subcutaneous **interferon beta-1a vs standard care** in patients with mild to critical COVID-19 admitted to 405 centers in 30 countries were published as preprint [85, 91]. In 11,266 adults were randomized, with 2750 allocated remdesivir, 954 hydroxychloroquine, 1411 lopinavir, 651 interferon plus lopinavir, 1412 only interferon, and 4088 no study drug. Death rate ratio for interferon was not statistically significant different in comparision with control group: RR=1.16 (0.96-1.39, p=0.11; 243/2050 vs 216/2050) (or 1.12, 0.83-1.51, without lopinavir co-administration). The same is true for outcomes Initiation of ventilation or Hospitalisation duration.

RCT
40 Pts.
geringe Unterschiede bei Endpunkten

Pandit et al. 2021 [142] published results of RCT conducted in 40 patients with moderate COVID-19 (PEG IFN-α2b plus SOC, or SOC alone). The primary endpoint was improvement in clinical status on day 15, measured by the WHO 7-point ordinal scale. Overall, 19 (95.00%) subjects in PEG IFN-α2b plus SOC had achieved clinical improvement on day 15 compared to 13 (68.42%) subjects in SOC (p< 0.05); 80% and 95% of subjects in the PEG IFN-α2b plus SOC group had a negative RT-PCR result on day 7 and day 14, respectively, compared to 63% and 68% in the SOC group. Adverse events were reported for eleven subjects in the PEG IFN-α2b plus SOC group and eight subjects in the SOC group. All reported AEs were mild.

sehr niedrige Evidenz: Vorteile bei Gesamtmortalität

Summary of Findings table related to **meta-analysis** on results of **3 RCTs** (Davoudi-Monfared, Rahmani, SOLIDARITY-INF), on comparisons of **interferon beta-1a vs standard of care** in patients with moderate/severe/critical COVID-19 patients, is presented in Table 3.11-1. In summary, according to currently available very low certainty of evidence, the evidence is very uncertain about the effect of interferon beta-1a on outcomes: WHO progression score level 6 or above D14-D28 (RR 0.46, 95% CI 0.24 to 0.90, 2 RCTs): WHO progression score level 7 or above D14-D28 (RR 0.46, 95% CI 0.24 to 0.90, 2 RCTs); All-cause mortality D7 (RR 0.11, 95% CI 0.01 to 0.91, 2 RCTs) and All-cause mortality D14-28 (RR 0.68, 95% CI 0.32 to 1.45, 3 RCTs).

3-armiger RCT:
60 Patient*innen schwer Erkrankung

bessere klin. Ergebnnisse und Mortalität unter IFNβ1a und IFNβ1b

Darazam et al. [143] published as preprint results from three-armed, individually-randomized, open-label, controlled trial of **IFNβ1a** and **IFNβ1b**, comparing them against each other and a **control** group (**NCT04343768**). Patients were randomly assigned in a 1:1:1 ratio to IFNβ1a (subcutaneous injections of 12,000 IU on days 1, 3, 6), IFNβ1b (subcutaneous injections of 8,000,000 IU on days 1, 3, 6), or the control group. A total of 60 severely ill patients with positive RT-PCR and Chest CT scans underwent randomization (20 patients to each arm). In the Intention-To-Treat population, IFNβ1a was associated with a significant difference against the control group, in the outcome Time to clinical improvement (; (HR; 2.36, 95% CI=1.10-5.17, p=0.031) while the IFNβ1b indicated no significant difference compared with the control; HR; 1.42, (95% CI=0.63-3.16, p=0.395). The mortality was numerically lower in both of the intervention groups (20% in the IFNβ1a

group and 30% in the IFNβ1b group vs. 45% in the control group). There were no significant differences between the three arms regarding the adverse events.

Table 3.11-1: Summary of findings table on ***Interferon β-1a compared to Standard Care for Moderate/Severe/Critical COVID-19*** *(3 RCTs: Davoudi-Monfared, Rahmani, SOLIDARITY-INF) – https://covid-nma.com/living_data/index.php*

Interferon β compared to Standard Care for Moderate/Severe/Critical COVID-19

Patient or population: Moderate/Severe/Critical COVID-19
Setting: Worldwide
Intervention: Interferon β
Comparison: Standard Care

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	No of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care	Risk with Interferon β				
Viral negative conversion - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score level 6 or above D7	293 per 1,000	**149 per 1,000** (59 to 375)	**RR 0.51** (0.20 to 1.28)	165 (2 RCTs) [b]	⨁◯◯◯ VERY LOW [c,d,e]	
WHO progression score level 6 or above D14-D28	268 per 1,000	**123 per 1,000** (64 to 241)	**RR 0.46** (0.24 to 0.90)	165 (2 RCTs) [b]	⨁◯◯◯ VERY LOW [c,d,f]	
WHO progression score level 7 or above D7	256 per 1,000	**149 per 1,000** (79 to 277)	**RR 0.58** (0.31 to 1.08)	165 (2 RCTs) [b]	⨁◯◯◯ VERY LOW [c,g,h]	
WHO progression score level 7 or above D14-D28	268 per 1,000	**123 per 1,000** (64 to 241)	**RR 0.46** (0.24 to 0.90)	165 (2 RCTs) [b]	⨁◯◯◯ VERY LOW [c,f,g]	
All-cause mortality D7	134 per 1,000	**15 per 1,000** (1 to 122)	**RR 0.11** (0.01 to 0.91)	165 (2 RCTs) [b]	⨁◯◯◯ VERY LOW [c,f,g]	
All-cause mortality D14-D28	112 per 1,000	**76 per 1,000** (36 to 163)	**RR 0.68** (0.32 to 1.45)	4265 (3 RCTs) [i]	⨁◯◯◯ VERY LOW [g,j,k]	
Adverse events - not reported	-	-	-	-	-	outcome not yet measured or reported
Serious adverse events - not reported	-	-	-	-	-	outcome not yet measured or reported

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty**: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last update: November 10, 2020; b. Davoudi-Monfared E, 2020; Rahmani H, 2020; c. Risk of bias downgraded by 2 levels: some concerns regarding adequate randomization, outcome measurement and selection of reported results, and high risk regarding deviations from intended interventions and missing data; d. Indirectness downgraded by 1 level: studies from a single country, therefore results in this population might not be generalizable to other settings; e. Imprecision downgraded by 2 levels: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants and events; f. Imprecision downgraded by 1 level: due to low number of events and/or participants; g. Risk of bias downgraded by 2 levels: some concerns regarding adequate randomization and selection of reported results, and high risk regarding deviations from intended interventions and missing data; h. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect and low number of participants and events; i. Davoudi-Monfared E, 2020; Rahmani H, 2020; SOLIDARITY, 2020; j. Inconsistency downgraded by 1 level: I^2=71.2%; k. Imprecision downgraded by 2 levels: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm

3.12 Convalescent plasma transfusion

About the treatment under consideration

(Re-) Konvaleszenzplasma von covid-19 Patient*innen, die sich von der Erkrankung bereits erholt haben

auch zur Herstellung von Immunglobulin-konzentraten verwendet

Convalescent plasma is plasma collected from patients that have recovered from an infectious disease and can be transfused to patients fighting an infection or can be used to manufacture immune globulin concentrates (plasma derived medicinal products). Possible explanations for the efficacy are that the antibodies from convalescent plasma might suppress viraemia and activate the complement system, thus promoting viral elimination. Antibody is most effective when administered shortly after the onset of symptoms, and a sufficient amount of antibody must be administered. Plasma transfusions may be associated with transfusion reactions such as allergic reactions, antibody-mediated enhancement of infection, transfusion-related acute lung injury (TRALI) and circulatory overload [144-146]. Rare complications include the transmission of infectious pathogens and red cell alloimmunization.

EMA & FDA Guidance zu CVP

The European Commission (EC) and US Food and Drug Administration (FDA) published guidance on convalescent plasma collected from individuals who have recovered from COVID-19 [147, 148]. The EC guidance aims to facilitate a common approach across EU Member States to the donation, collection, testing, processing, storage, distribution and monitoring of convalescent plasma for the treatment of Covid-19 [147]. The FDA guidance provides recommendations on the pathways for use of investigational COVID-19 convalescent plasma; patient eligibility; collection of COVID-19 convalescent plasma, including donor eligibility and donor qualifications; labeling and record keeping. As COVID-19 convalescent plasma is regulated as an investigational product, three patways for use are available in US: 1. Clinical Trials; 2. Expanded Access; 3. Single Patient Emergency IND [148, 149].

FDA im August 2020: Emergency UseAuthorization (EUA)

Feb 2021: EUA Revision

Verabreichung von Rekonvalszentenplasma nur mehr im frühen Stadium von hospitaliserten Patient*innen und mit Plasma mit hohem Titer zugelassen

On August 23, 2020 the FDA issued an **emergency use authorization (EUA)** for investigational convalescent plasma for the treatment of COVID-19 in hospitalized patients [150]. On **February 4 2021, FDA** announced that this **EUA** is **being revised** to authorize **only the use of high titer COVID-19 convalescent plasma**, for the treatment of **hospitalized patients** with COVID-19, **early in the disease course** and those hospitalized with **impaired humoral immunity**. The use of low titer COVID-19 convalescent plasma is no longer authorized under this EUA. COVID-19 convalescent plasma should not be considered a new standard of care for the treatment of patients with COVID-19. Given that the clinical evidence supporting this EUA remains limited, data from additional randomized, controlled trials are needed. Under this EUA, authorized COVID-19 convalescent plasma will be obtained from registered or licensed blood establishments from donors in the United States or its territories in accordance with applicable regulations, policies, and procedures. Testing for relevant transfusion-transmitted infections must be performed and the donation must be found suitable. Plasma donations must be tested by registered or licensed blood establishments for anti-SARSCoV-2 antibodies as a manufacturing step to determine suitability before release, using one of the tests listed in the EUA document, https://www.fda.gov/media/141477/download.

Current US **NIH COVID-19 Treatment Guidelines** stated that there are insufficient clinical data to recommend either for or against the use of convalescent plasma for the treatment of COVID-19 (February 2021) [151].

US NIH COVID-19 Treatment Guidelines: insuffiziente Datenlage weder für noch gegen CVP

Withdrawn, suspended or terminated studies

1 RCT was found as withdrawn in US, NCT04467151 (did not obtain funding to proceed) and 1 RCT found as terminated in Italy, NCT04393727, the Promoter was changed and a new study promoted by AIFA started).

1 RCT zurückgezogen

Results of publications

Li et al. 2020 published results from RCT (**ChiCTR200029757**) [152] conducted in 103 patients with COVID-19 (**severe to critical**) admitted to 7 centers in China. Convalescent plasma therapy added to standard treatment, compared with standard treatment alone, did not result in a statistically significant improvement in time to clinical improvement within 28 days (51.9% (27/52) of the convalescent plasma group vs 43.1% (22/51) in the control group (difference, 8.8% [95% CI, −10.4% to 28.0%]; hazard ratio [HR], 1.40 [95% CI, 0.79-2.49]; p =0.26). Among those with severe disease, the primary outcome was statistically significant in favour of convalescent plasma (91.3% (21/23) vs 68.2% (15/22) of the control group (HR, 2.15 [95% CI, 1.07-4.32]; p = 0.03); among those with life-threatening disease the primary outcome occurred in 20.7% (6/29) of the convalescent plasma group vs 24.1% (7/29) of the control group (HR, 0.88 [95% CI, 0.30-2.63]; p = 0.83) (P for interaction = 0.17). There was no significant difference in 28-day mortality (15.7% vs 24.0%; OR, 0.65 [95% CI, 0.29-1.46]; p =0.30) or time from randomization to discharge (51.0% vs 36.0% discharged by day 28; HR, 1.61 [95% CI, 0.88-2.93]; p = 0.12). Two patients in the convalescent plasma group experienced adverse events within hours after transfusion that improved with supportive care. Interpretation of results is limited by early termination of the trial, which may have been underpowered to detect a clinically important difference.

Li (China)
RCT, 103 Pts (statt 200, wegen Mangel an Pts)

keine Unterschiede bei Endpunkten

Gharbharan et al. 2020 [153], published results as **preprint,** from prematurely **halted RCT** (**NCT04342182**), performed on 86 patients with COVID-19 (moderate-critical) admitted to 14 centers in the Netherlands [153].

RCT (Niederlande): 86 Pts.,

Avendano-Sola et al. 2020 published as **preprint,** results of multi-center RCT (**NCT04345523**) [154]: All patients received standard of care treatment, including off-label use of marketed medicines, and were randomized 1:1 to receive one dose (250-300 mL) of CP from donors with IgG anti-SARS-CoV-2. The trial was stopped after first interim analysis due to the fall in recruitment related to pandemic control. With 81 patients randomized, there were no patients progressing to mechanical ventilation or death among the 38 patients assigned to receive plasma (0%) versus 6 out of 43 patients (14%) progressing in control arm. Mortality rates were 0% vs 9.3% at days 15 and 29 for the active and control groups, respectively. No significant differences were found in secondary endpoints.

Sept 2020: Publikation zu RCT CVP vs. SOC

frühzeitiger Abbruch wegen Mangel an Rekrutierung: Interim Analyse von 81 Pts

Agarwal et al. 2020 [155] [156] reported results from open-label, parallel-arm, phase 2, multicentre, randomized controlled trial in India (**CTRI/2020/04/024775**) conducted on hospitalized, **moderately ill** confirmed COVID-19 patients (PaO2/FiO2: 200-300 or respiratory rate > 24/min and SpO2 ≤ 93% on room air). 464 participants were enrolled; 235 and 229 in intervention and control arm, respectively. Composite primary outcome (progression to severe disease or all cause mortality at 28 days) was achieved in 44 (19%) participants in the intervention arm and 41 (18%) in the control arm (risk difference 0.008 (95% confidence interval -0.062 to 0.078); risk ratio 1.04, 95% confidence interval 0.71 to 1.54

Okt 2020
preprint RCT
(open-label)
Indien
464 Pts

kein Unterschied bei Mortalität oder Fortschreiten der Krankheit

Balcells et al. 2020 [157] reported, as preprint, results from open-label, single-center, randomized clinical trial performed in an academic center in Santiago, Chile, including 58 patients (**NCT04375098**). No benefit was found in the primary outcome (32.1% vs 33.3%, OR 0.95, 95% CI 0.32-2.84, p>0.99) in the early versus deferred CP group. In-hospital mortality rate was 17.9% vs 6.7% (OR 3.04, 95% CI 0.54-17.2, p=0.25), mechanical ventilation 17.9% vs 6.7% (OR 3.04, 95% CI 0.54-17.2, p=0.25), and prolonged hospitalization 21.4% vs 30% (OR 0.64, 95%CI, 0.19-2.1, p=0.55) in early versus deferred CP group, respectively. Viral clearance rate on day 3 (26% vs 8%, p=0.20) and day 7(38% vs 19%, p=0.37) did not differ between groups. Two patients experienced serious adverse events within 6 or less hours after plasma transfusion.

preprint RCT
(open-label)
Chile
58 Pts

kein Unterschied bei Mortalität, Dauer des Krankenhausaufenthalts und künstlicher Beatmung

Simonovich et al 2020 [158] published results from RCT (NCT04383535) in hospitalised adult patients with **severe Covid-19 pneumonia**. A total of 228 patients were assigned to receive convalescent plasma and 105 to receive placebo. The median time from the onset of symptoms to enrollment in the trial was 8 days (interquartile range, 5 to 10), and hypoxemia was the most frequent severity criterion for enrollment. The infused convalescent plasma had a median titer of 1:3200 of total SARS-CoV-2 antibodies (interquartile range, 1:800 to 1:3200]. At day 30 day, no significant difference was noted between the convalescent plasma group and the placebo group in the distribution of clinical outcomes according to the ordinal scale (odds ratio, 0.83 (95% confidence interval [CI], 0.52 to 1.35; p=0.46). Overall mortality was 10.96% in the convalescent plasma group and 11.43% in the placebo group, for a risk difference of -0.46 percentage points (95% CI, -7.8 to 6.8). Adverse events and serious adverse events were similar in the two groups.

RCT
228 Patient*innen
kein Unterschied

Libster et al. 2021 [159] published results from randomised, double-blind, placebo-controlled trial of convalescent plasma with high IgG titers against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in older adult patients within 72 hours after the onset of **mild Covid-19** symptoms (NCT04479163; PAEPCC19; Plataforma PRIISA (1421)). The trial was stopped early at 76% of its projected sample size because cases of Covid-19 in the trial region decreased considerably and steady enrollment of trial patients became virtually impossible. A total of 160 patients underwent randomisation. In the intention-to-treat population, severe respiratory disease developed in 13 of 80 patients (16%) who received convalescent plasma and 25 of 80 patients (31%) who received placebo (relative risk, 0.52; 95% confidence interval [CI], 0.29 to 0.94; p=0.03), with a relative risk reduction of 48%. A modified intention-to-treat analysis that excluded 6 patients who had a primary end-point event before infusion of convalescent plasma or placebo showed a larger effect size (relative risk, 0.40; 95% CI, 0.20 to 0.81). No solicited adverse events were observed.

RCT 160 Pts
milde Erkrankung

Vorteile bei Fortschreiten zu schwerer Atemwegserkrankung

keine Nebenwirkungen

Two more RCTs was found as preprint publications: **AlQahtani et al. 2020** (NCT04356534); and **Ray et al. 2020** (CTRI/2020/05/025209); results will be presented after peer-review publication. **Rasheed et al. 2020** published results from RCT in Iraq [160] on forty nine early-stage **critically-ill COVID-19** patients residing in Respiratory Care Units (RCU): 21 received convalescent plasma while 28, namely control group, did not receive it. Recovery or death, length of stay in hospital, and improvement in the clinical course of the disease were monitored clinically along with laboratory monitoring through SARS-CoV-2 RNA detection via PCR, and SARS-CoV-2 IgG and IgM serological monitoring. Patients who received convalescent plasma showed reduced duration of infection in about 4 days and showed less death rate [1/21 versus 8/28 in control group]. In addition, all the patients who were given convalescent plasma showed high levels of SARS-CoV-2 IgG and IgM three days after plasma transfusion. Plasma from donors with high levels of SARS-CoV-2 IgG and donors with positive SARS-CoV-2 IgM showed better therapeutic results than other donors. Authors concluded that convalescent plasma therapy is an effective therapy if donors with high level of SARSCov2 antibodies are selected and if recipients are at their early stage of critical illness, being no more than three days in RCU.

2 weitere RCTs in preprint

in SoF Tabelle präsentiert

1 RCT (Irak)
49 Pts.

positive Ergebnisse, insb. bei Plasma mit hohem Titer (Antikörper)

Salman et al. 2020 published preliminary results from RCT in Egypt [161] conducted in 30 patients with **severe COVID-19** infection. In convalescent plasma group, there was statistically significant improvement of clinical parameters, as well as serum ferritin, D-dimer, c-reactive protein, and the size of lung lesion compared to control group ($p \leq 0.05$). COVID-19 neutralizing antibodies appeared in serum of convalescent plasma patients, but failed to show in the control group patients during 5 days study period.

1 RCT (Ägypten)
30 Pts.

bessere klinische Parameter mit CVP

The **RECOVERY trial independent Data Monitoring Committee** (DMC) held a routine meeting on Thursday 14 January to review the available safety and efficacy data. On **January 15, 2021 the RECOVERY trial** chief investigators relesead the statement related to recruitment to convalescent plasma treatment for hospitalised with COVID-19. On the advice of the independent Data Monitoring Committee (DMC), **recruitment to the convalescent plasma arm** of the RECOVERY trial has now **closed**. The DMC saw no convincing evidence that further recruitment would provide conclusive proof of worthwhile mortality benefit either overall or in any pre-specified subgroup [162].

RECOVERY
Therapiearm geschlossen, da Ergebnisse keinen Unterschied bei 28-Tages Mortalität zeigen

The **RECOVERY Collaborative Group** published as **preprint** results from the RECOVERY trial [163] 5795 **hospitalised patients** were randomly allocated to receive high-titre convalescent plasma and 5763 to usual care alone. **At randomisation**, 617 (**5%**) were receiving **invasive mechanical ventilation**, 10044 (**87%**) were **receiving oxygen only** (with or without non-invasive respiratory support), and 897 (**8%**) were receiving **no oxygen therapy**. 92% of patients were receiving corticosteroids at time of randomisation. There was no significant difference in 28-day mortality between the two groups: 1398 (24%) of 5795 patients allocated convalescent plasma and 1408 (24%) of 5763 patients allocated usual care died within 28 days (rate ratio [RR] 1.00; 95% confidence interval [CI] 0.93 to 1.07; p=0.93). The 28-day mortality rate ratio was similar in all prespecified subgroups of patients, including in those patients without detectable SARS-CoV-2 antibodies at randomisation. Allocation to convalescent plasma had no significant effect on the proportion of patients discharged from hospital within 28 days (66% vs. 67%; rate ratio 0.98; 95% CI 0.94-1.03, p=0.50). Among those not on invasive mechanical ventilation at baseline, there was no significant difference in the proportion

Publikation von RECOVERY
5.795 Patient*innen mit CVP

kein Unterschied bei 28-Tages Mortalität sowie bei kombiniertem Endpunkt Progression und Tod

ABER:
auch CVP mit hohem Titer an Antikörpern machten keinen Unterschied

meeting the composite endpoint of progression to invasive mechanical ventilation or death (28% vs. 29%; rate ratio 0.99; 95% CI 0.93-1.05, p=0.79). Among patients hospitalised with COVID-19 (87% with severe disease and 5% with invasive mechanical ventilation; 8% no oxygen therapy), high-titre convalescent plasma did not improve survival or other prespecified clinical outcomes.

RCT (Brasilien)
223 Pts.

Unterschied bei
28-Tage Mortalität
(nicht aber bei klinischer
Vrebesserung)

O'Donnell et al. 2021 [164] published as preprint results from RCT (NCT04359810) in US and Brazil on 223 **severe COVID-19** patients (150 were randomized to receive convalescent plasma and 73 to normal control plasma). At 28 days, no significant improvement in clinical status was observed in participants randomized to convalescent plasma (with an odds ratio (OR) of a 1-point improvement in the scale: 1.50, 95% confidence interval (CI) 0.83-2.68, p=0.180). 28-day mortality was significantly lower in participants randomized to convalescent plasma versus control plasma (19/150 [12.6%] versus 18/73 [24.6%], OR 0.44, 95% CI 0.22-0.91, p=0.034). The median titer of anti-SARS-CoV-2 neutralizing antibody in infused convalescent plasma units was 1:160 (IQR 1:80-1:320). Serious adverse events occurred in 39/147 (27%) participants who received convalescent plasma and 26/72 (36%) participants who received control plasma.

Zusammenfassung von 13
RCTs:
kein Unterschied bei
Gesamtmortalität,
bei klinischer
Verbesserung

The **Living Systematic Review with meta-analysis**, related to **13 RCTs:** Li et al. 2020 [152], Gharbharan et al. 2020 [153], Avendano-Sola et al. 2020 [141], Agarwal et al. 2020 [155], Simonovich [158], AlQahtani et al. 2020, Libster et al. 2020 [159], Ray et al. 2020, Rasheed et al. 2020 [160], Salman et al. 2020 [161], Horby RECOVERY [165] , O'Donnell [164] and Bajpai et al. 2021, with **Summary of findings** table is provided in Table 3.12-1. In summary, according to currently available evidence, convalescent plasma probably does not reduce All-cause mortality D28 (RR 0.80, 95% CI 0.68 to 1.06, 10 RCTs, moderate certainty of evidence); probably does not increase incidence of clinical improvement D28 (RR 1.00, 95% CI 0.97 to 1.02, 5 RCTs, moderate certainty of evidence); probably does not decrease WHO progression score level 7 or above D28 (RR 0.80, 95% CI 0.68 to 1.06, 3 RCTs, moderate certainty of evidence); probably does not increase incidence of Adverse events (RR 1.11, 95% CI 0.96 to 1.28, 5 RCTs, moderate certainty of evidence) and may not increase Serious adverse events (RR 0.99, 95% CI 0.64 to 1.52, 7 RCTs, low certainty of evidence). The evidence is very uncertain about the effect of convalescent plasma on further outcome: Viral negative conversion D7 (RR 1.64, 95% CI 0.88 to 3.06, 3 RCTs, very low certainty of evidence).

Table 3.12-1: Summary of findings table on ***Convalescent plasma compared to Standard Care for Mild/Moderate/Severe/Critical COVID-19***
(13 RCTs: Li, Gharbharan, Avendano-Sola, Agarwal, AlQahtani, Simonovich, Libster, Ray, Rasheed, Salman, Horby RECOVERY, ODonnell, Bajpai)

Convalescent plasma compared to Standard Care for Mild/Moderate/Severe/Critical COVID-19
Patient or population: Mild/Moderate/Severe/Critical COVID-19
Setting: Worldwide
Intervention: Convalescent plasma
Comparison: Standard Care

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care	Risk with Convalescent plasma				
Viral negative conversion D7	482 per 1,000	**791 per 1,000** (424 to 1,000)	**RR 1.64** (0.88 to 3.06)	459 (3 RCTs) [b]	⨁◯◯◯ VERY LOW [c,d,e]	
Clinical improvement D28	655 per 1,000	**655 per 1,000** (635 to 668)	**RR 1.00** (0.97 to 1.02)	12121 (5 RCTs) [f]	⨁⨁⨁◯ MODERATE [g]	
Clinical improvement D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above) D28	203 per 1,000	**162 per 1,000** (116 to 223)	**RR 0.80** (0.57 to 1.10)	638 (3 RCTs) [h]	⨁⨁⨁◯ MODERATE [e,i]	
WHO progression score (level 7 or above) D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D28	237 per 1,000	**190 per 1,000** (161 to 252)	**RR 0.80** (0.68 to 1.06)	13000 (10 RCTs) [j]	⨁⨁⨁◯ MODERATE [k,j]	
All-cause mortality D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
Adverse events	328 per 1,000	**364 per 1,000** (315 to 420)	**RR 1.11** (0.96 to 1.28)	851 (5 RCTs) [m]	⨁⨁⨁◯ MODERATE [n,o]	
Serious adverse events	126 per 1,000	**125 per 1,000** (81 to 192)	**RR 0.99** (0.64 to 1.52)	1018 (7 RCTs) [p]	⨁⨁◯◯ LOW [n,q]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; **RR**: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty**: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty**: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty**: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last update: April 13, 2021; b. Agarwal A, PLACID, 2020; Li L, 2020; Salman OH, 2020; c. Risk of bias downgraded by 2 levels: some concerns regarding adequate randomization, deviation from intended interventions, and selection of reported results. High risk of bias due to missing data.; d. Inconsistency downgraded by 1 level: I^2=76%; e. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect and low number of participants; f. Horby P, RECOVERY, 2021; AlQahtani M, 2020; Gharbharan A, 2020; Li L, 2020; Simonovich VA, PlasmAr, 2020; g. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviation from intended intervention, outcome measurement and selection of reported results; h. Avendaño-Solà C, 2020; Simonovich VA, 2020, O Donnell M, 2021; i. Despite some concerns with selection of reported results, not downgraded for risk of bias because the study with these concerns contributed only a small proportion of the data.; j. AlQahtani M, 2020; Avendaño-Solà C, 2020; Agarwal A, PLACID, 2020; Horby P, RECOVERY, 2021; Gharbharan A, 2020; Li L, 2020; Simonovich VA, PlasmAr, 2020; Ray Y, 2020, O Donnell M, 2021; Bajpai M, 2020; k. Despite concerns regarding sequence generation, deviation from intended interventions, and selection of reported results, not downgraded for risk of bias because the studies with these concerns contributed only a small proportion of the data.; l. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect; m. Li L, 2020; Libster R, 2020; Simonovich VA, 2020, O Donnell M, 2021; Bajpai M, 2020; n. Despite concerns regarding deviations from intervention, outcome measurement and selection of reported results, not downgraded for risk of bias because the studies with these concerns contributed only a small proportion of the data.; o. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for no effect and the possibility for harm and low number of participants
p. Avendaño-Solà C, 2020; Gharbharan A, 2020; Li L, 2020; Libster R, 2020; Simonovich VA, 2020, O Donnell M, 2021; Bajpai M, 2020; q. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants

3.13 Plasma derived medicinal products

Neutralizing monoclonal antibodies

neutralisierende monoklonale Antikörper: Prävention und Behandlung

Halbwertszeit bis 3 Wochen von Vorteil

Nachteil: unbekannte Bioverfügbarkeit der infundierten Antikörper

As Marovich et al. 2020 [166] stated, **neutralizing monoclonal antibodies** to SARS-CoV-2 have the potential to be used for both prevention and treatment of infection. They can help to guide vaccine design and development as well. The main target of SARS-CoV-2 neutralizing monoclonal antibodies is the surface spike glycoprotein that mediates viral entry into host cells. Some products will include of a combination of 2 monoclonal antibodies targeting different sites on the spike protein. Due to long half-life of most monoclonal antibodies (approximately 3 weeks for IgG1), a single infusion should be sufficient. A potential limitation of monoclonal antibodies for treatment of COVID-19 is the unknown bioavailability of passively infused IgG in tissues affected by the disease, especially the lungs, which serve as a key target of SARS-CoV-2 infection. Due to the effect of viral diversity it will be important to monitor for the emergence of resistant viral mutations under selective pressure of monoclonal antibody treatment.

Possible disease enhancement include antibody-mediated enhancement of viral entry and replication in target cells (Fc-bearing monocytes or macrophages) and virus-antibody immune complexes and the associated cytokine release [166].

3.13.1 REGN-COV2 - combination of two monoclonal antibodies (REGN10933 and REGN10987)

Kombination aus 2 monoklonalen Antikörpern: Casirivimab + Imdevimab

REGN-COV2 is combination of two monoclonal antibodies (REGN10933 and REGN10987) which bind non-competitively to the critical receptor binding domain of the virus's spike protein, which diminishes the ability of mutant viruses to escape treatment and protects against spike variants that have arisen in the human population.

Phase 3 REGNCOV2 Studie NIAID (NIH) Studie mit 2.000 Teilnehmer*innen

A **phase 3 prevention trial** evaluates REGNCOV2's ability to prevent infection among uninfected people who have had close exposure to a COVID-19 patient (such as the patient's housemate) at approximately 100 sites and is expected to enroll 2,000 patients in the U.S.; the trial will assess SARS-CoV-2 infection status.

Behandlung von hospitalisierten und ambulanten Patiente*innen 1.050 Pts. In Planung

REGN-COV2 has also moved into the **phase 2/3** portion of **two adaptive phase 1/2/3 trials** testing the cocktail's ability **to treat hospitalised and non-hospitalised (or "ambulatory") patients with COVID-19**. The two phase 2/3 treatment trials in hospitalized (estimated enrollment =1,850) and non-hospitalized (estimated enrollment =1,050) patients are planned to be conducted at approximately 150 sites in the U.S., Brazil, Mexico and Chile, and will evaluate virologic and clinical endpoints, with preliminary data expected later this summer.

Sept 2020: RECOVERY nimmt REGNCOV2 als Studienmedikament auf

On September 14, 2020 the University of Oxford and Regeneron Pharmaceuticals, Inc. announced that **RECOVERY** (Randomised Evaluation of COVid-19 thERapY will evaluate Regeneron's investigational anti-viral antibody cocktail, REGNCOV2, https://www.recoverytrial.net/news/recovery-covid-19-phase-3-trial-to-evaluate-regeneron2019s-regn-cov2-investigational-antibody-cocktail-in-the-

uk. The phase 3 open-label trial in patients hospitalised with COVID-19 will compare the effects of adding REGN-COV2 to the usual standard-of-care versus standard-of-care on its own.

New SARS-CoV-2 Variants

in präklinischer Forschung: REGN-COV auch gegen Mutationen wirksam

On January 27, 2021, Regeneron Pharmaceuticals, Inc. announced that researchers in Columbia University lab [167] and Regeneron scientists have independently confirmed that REGEN-COV™ (casirivimab and imdevimab antibody cocktail) successfully neutralizes the circulating SARS-CoV-2 variants first identified in the UK (B.1.1.7) and South Africa (B.1.351), in preclinical research. Both antibodies retaining their potency against the B.1.1.7 variant; against the B.1.351 variant, imdevimab retained its potency and, while the casirivimab potency was reduced, it was still comparable to the potency that other single antibodies in development have against the original virus. Regeneron is conducting additional preclinical research against the variant first identified in Brazil (1.1.248), https://investor.regeneron.com/news-releases/news-release-details/regen-covtm-antibody-cocktail-active-against-sars-cov-2-variants.

FDA Analyse zur Wirksamkeit bei unterschiedlichen Mutationen:

gleiche Wirksamkeit

In the FDA new revision related to REGN-COV2 and new variants, published on March 2021, casirivimab and imdevimab individually and together retained neutralization activity against pseudovirus expressing all spike protein substitutions found in the B.1.1.7 lineage (UK origin) and against pseudovirus expressing only N501Y found in B.1.1.7 and other circulating lineages (Table 3.13-1). Casivirimab and imdevimab together retained neutralization activity against pseudovirus expressing all spike protein substitutions, or individual substitutions K417N, E484K or N501Y, found in the B.1.1351 lineage (South Africa origin), and against K417T+E484K, found in the P.1 lineage (Brazil origin), although casirivimab alone, but not imdevimab, had reduced activity against pseudovirus expressing K417N or E484K, as indicated above. The E484K substitution is also found in the B.1.526 lineage (New York origin). Casivirimab and imdevimab, individually and together, retained neutralization activity against the L452R substitution found in the B.1.427/B.1.429 lineages (California origin). It is not known how pseudovirus data correlate with clinical outcomes [168].

Table 3.13-1. Pseudovirus neutralization data for SARS-CoV-2 variant substitutions with Casirivimab and Imdevimab together

Lineage with Spike Protein Substitution	Key substitutions tested	Fold reduction in susceptibility
B.1.1.7 (UK origin)	N501Y [a]	no change [c]
B.1.351 (South Africa origin)	K417N, E484K, N501Y [b]	no change [c]
P.1 (Brazil origin)	K417T + E484K	no change [c]
B.1.427/B.1.429 (California origin)	L452R	no change [c]
B.1.526 (New York origin) [d]	E484K	no change [c]

a Pseudovirus expressing the entire variant spike protein was tested. The following changes from wild-type spike protein are found in the variant: del69-70, del145, N501Y, A570D, D614G, P681H, T716I, S982A, D1118H.

b Pseudovirus expressing the entire variant spike protein was tested. The following changes from wild-type spike protein are found in the variant: D80Y, D215Y, del241-243, K417N, E484K, N501Y, D614G, A701V.

c No change: <2-fold reduction in susceptibility.

d Not all isolates of the New York lineage harbor the E484K substitution (as of February 2021).

Source: [168]

US COVID-19 Treatment Guidelines (update April 8, 2021)

US COVID-19 Treatment Guidelines Panel

- The **US COVID-19 Treatment Guidelines Panel** recommends using one of the following combination anti-SARS-CoV-2 monoclonal antibodies to treat outpatients with mild to moderate COVID-19 who are at high risk of clinical progression, as defined by the EUA criteria (listed in alphabetical order):
  - **Bamlanivimab 700 mg plus etesevimab 1,400 mg (AIIa);** *or*
  - **Casirivimab 1,200 mg plus imdevimab 1,200 mg (AIIa)**.

Empfehlung für Antikörper Kombinationstherapien

Bamlanivimab + Etesevimab oder Casirivimab + Imdevimab

- Treatment should be started as soon as possible after the patient receives a positive result on a SARS-CoV-2 antigen or nucleic acid amplification test (NAAT) and within 10 days of symptom onset.
- There are no comparative data to determine whether there are differences in clinical efficacy or safety between bamlanivimab plus etesevimab and casirivimab plus imdevimab.
  - There are SARS-CoV-2 variants, particularly those that contain the mutation E484K, that reduce the virus' susceptibility to bamlanivimab and, to a lesser extent, casirivimab and etesevimab in vitro; however, the clinical impact of these mutations is not known.
  - In regions where SARS-CoV-2 variants with reduced in vitro susceptibility to bamlanivimab plus etesevimab are common, some Panel members would preferentially use casirivimab plus imdevimab while acknowledging that it is not known whether in vitro susceptibility data correlate with clinical outcomes.

keine Vergleichsstudien

- Because clinical outcome data are limited and there are concerns regarding decreased susceptibility of variants, the Panel **recommends against** the use of **bamlanivimab monotherapy (AIII).**
  - If combination products are not available, the use of bamlanivimab monotherapy can be considered for people who meet the EUA criteria on a case-by-case basis.

Empfehlung gegen Antikörper Monotherapie Bamlanivimab

- The Panel **recommends against** the use of **anti-SARS-CoV-2 monoclonal antibodies** for patients who are hospitalized because of COVID-19, except in a clinical trial **(AIIa**). However, their use should be considered for persons with mild to moderate COVID-19 who are hospitalized for a reason other than COVID-19 but who otherwise meet the EUA criteria [151].

Empfehlung gegen Antikörpertherapie bei hospitalisierten Patient*innen

Results of publication

Phase 2/3 RCT
799 ambulante Pts.

Firmenankündigung zu positive Efekten

Endpunkte:
Reduktion der Viruslast
Artzt-/ Notfall-/ Spitalsbesuche

On Oct 28, 2020 Regeneron Pharmaceuticals, Inc. announced **positive results** from an **ongoing phase 2/3 RCT** in the COVID-19 **outpatient setting** (ambulatory patients, n=799) on their website; the trial met the primary and key secondary endpoints. REGN-COV2 significantly reduced viral load and patient medical visits (hospitalizations, emergency room, urgent care visits and/or physician office/telemedicine visits), by 57% through day 29 (2.8% combined dose groups; 6.5% placebo; p=0.024) and by 72% in patients with one or more risk factor (including being over 50 years of age; body mass index greater than 30; cardiovascular, metabolic, lung, liver or kidney disease; or immunocompromised status) (combined dose groups; nominal p=0.0065). Manufacturer will submit detailed results from this trial for publication, https://www.prnewswire.com/news-releases/regenerons-covid-19-outpatient-trial-prospectively-demonstrates-that-regn-cov2-antibody-cocktail-significantly-reduced-virus-levels-and-need-for-further-medical-attention-301162255.html.

On December 17 2020, Weinreich et al. [169] published **preliminary results of phase 1-2 portion** of ongoing double-blind, **phase 1–3 trial (NCT04425629)** involving **nonhospitalised** patients with Covid-19, randomly assigned (1:1:1) to receive placebo, 2.4 g of REGN-COV2, or 8.0 g of REGN-COV2 and were prospectively characterized at baseline for endogenous immune response against SARS-CoV-2 (serum antibody–positive or serum antibody–negative). In this interim analysis, data from 275 patients are reported: the REGN-COV2 antibody cocktail reduced viral load, with a greater effect in patients whose immune response had not yet been initiated or who had a high viral load at baseline. The same is true for medically attended visit, with a greater effect among patients who were serum antibody–negative at baseline. The percentages of patients with hypersensitivity reactions, infusion-related reactions, and other adverse events were similar in the combined REGN-COV2 dose groups and the placebo group.

Teilergebnisse von Phase 1–3 RCT

275 Pts.

Vorteile bei Viruslastreduktion Reduktion von Arztbesuchen

Results announced by Regeneron Pharmaceuticals, Inc. on March 23, 2021

Regeneron Pharmaceuticals, Inc. announced positive results from the phase 3 above mentioned RCT assessing a COVID-19 treatment in infected non-hospitalized patients (n=4,567). This final phase 3 outcomes trial in high-risk non-hospitalized COVID-19 patients ("outpatients") met its primary endpoint, showing the investigational REGEN-COV™ (casirivimab with imdevimab) significantly reduced the risk of hospitalization or death by 70% (1,200 mg intravenous [IV]) and 71% (2,400 mg IV) compared to placebo, https://investor.regeneron.com/news-releases/news-release-details/phase-3-trial-shows-regen-covtm-casirivimab-imdevimab-antibody. REGEN-COV also met all secondary endpoints, including the ability to reduce symptom duration.

Phase 3 RCT
4567 ambulante (Hochrisiko) Pts.

Firmenankündigung zu positive Efekten
-70% Hospitaliserungen und/oder Tod

Dose-ranging Virology Trial

A companion dose-ranging phase 2 trial of 803 outpatient COVID-19 patients was conducted to evaluate the antiviral effect of several different REGEN-COV doses (IV: 2,400 mg, 1,200 mg, 600 mg and 300 mg; SC: 1,200 mg and 600 mg). All tested doses met the primary endpoint, rapidly and significantly reducing patients' viral load (log10 copies/mL) compared to placebo ($p<0.001$). Each dose demonstrated similar efficacy, including the lowest doses tested (IV: 300 mg; SC: 600 mg). In addition, a companion phase 2 trial showed that even the lowest doses tested (IV: 300 mg; subcutaneous [SC]: 600 mg) had significant viral load reductions over the first 7 study days, comparable to the 2,400 mg and 1,200 mg IV doses. A safety assessment conducted on all available patient data up to day 169 identified no new safety signals. Serious adverse events (SAEs) were largely related to COVID-19 and occurred in 1.1% of patients in the 1,200 mg group, 1.3% in the 2,400 mg group and 4.0% in the placebo group.

Phase 2
Dosisfindungsstudie
803 Pts.

auch niedrige Dosierungen reduzieren Viruslast

geringe Nebenwirkungen

Safety issue in hospitalised patients

On 30 October 2020, Regeneron Pharmaceuticals, Inc. received a recommendation from the independent data monitoring committee (IDMC) for the REGN-COV2 antibody cocktail treatment trials for COVID-19 that the current **hospitalised patient** trial be modified. Specifically, based on a potential safety signal and an unfavorable risk/benefit profile at this time, the IDMC recommends further enrollment of patients requiring high-flow oxygen or mechanical ventilation be placed on hold pending collection and analysis of further data on patients already enrolled. The IDMC also recommends continuing enrollment of hospitalised patients requiring either no or low-flow oxygen as the risk/benefit remains acceptable in these cohorts. Finally, the IDMC recommends continuation of the outpatient trial without

Sicherheitswarnung für Kohorte hospitalisierte und künstlich beatmete Pts.

modification, https://investor.regeneron.com/news-releases/news-release-details/regn-cov2-independent-data-monitoring-committee-recommends.

Regulatory update:

FDA: Notzulassung von von REGN-COV2

für milde bis moderate Erkrankung

On November 21, 2020, the U.S. Food and Drug Administration issued an **emergency use authorization (EUA)** for casirivimab and imdevimab to be administered together for the **treatment** of **mild to moderate COVID-19** in adults and pediatric patients (12 years of age or older weighing at least 40 kilograms [about 88 pounds]) with positive results of direct SARS-CoV-2 viral testing and who are **at high risk for progressing to severe COVID-19**. This includes those who are 65 years of age or older or who have certain chronic medical conditions [170].

Feb 2021: EMA beginnt "Rolling Review" zu REGN-COV

On **February 1st, 2021** EMA's human medicines committee (CHMP) has started a '**rolling review**' of data on REGN-COV2 antibody combination (casirivimab / imdevimab), based on preliminary results from a study that indicate a beneficial effect of the medicine in reducing the amount of virus in the nose and throat of non-hospitalised patients with COVID-19 [171]. Once finalised it will be the **basis for an EU marketing authorisation for this combination**.

EMA: REGN-COV2 kann für bestätigte Covid-19 Pts, die hohes Risiko auf Fortschreiten zu schwerer Erkrankung haben, eingestzt werden

On **February 26, 2021** EMA stated that the CHMP has completed its review to provide a **harmonised scientific opinion** at EU level to support national decision making on the possible use of the antibodies **before a formal authorisation is issued**. The Agency concluded that the combination (REGN-COV2) **can be used** for the treatment of **confirmed COVID-19 in patients who do not require supplemental oxygen and who are at high risk of progressing to severe COVID-19**. Risk factors may include but are not limited to advanced age; obesity; cardiovascular disease, including hypertension; chronic lung disease, including asthma; type 1 or type 2 diabetes mellitus; chronic kidney disease, including those on dialysis; chronic liver disease; immunosuppressed, based on prescriber's assessment [172, 173].

Regeneron Koperation mit Roche

Regeneron is collaborating with Roche to increase global supply of REGEN-COV2. Regeneron is responsible for development and distribution of the treatment in the U.S., and Roche is primarily responsible for development and distribution outside the U.S.

3.13.2 LY-CoV555 - neutralizing IgG1 monoclonal antibody (bamlanivimab) and LY-CoV016 - recombinant fully human monoclonal neutralizing antibody (etesevimab)

2 weitere mAb: LY-CoV555 (Bamlanivimab)

LY-CoV555 is a neutralizing IgG1 monoclonal antibody (mAb) directed against the spike protein of SARS-CoV-2. It is designed to block viral attachment and entry into human cells, thus neutralizing the virus, potentially preventing and treating COVID-19.

LY-CoV016 (Etesevimab)

LY-CoV016 (also known as JS016) is a recombinant fully human monoclonal neutralizing antibody, which specifically binds to the SARS-CoV-2 surface spike protein receptor binding domain with high affinity and can effectively block the binding of the virus to the ACE2 host cell surface receptor.

LY-CoV555: Phase 1

Lilly has successfully completed enrollment and primary safety assessments of LY-CoV555 in a **phase 1** study of hospitalised patients with COVID-19 (NCT04411628) and long-term follow-up is ongoing.

BLAZE-1 (NCT04427501) is ongoing randomized, double-blind, placebo-controlled **phase 2** study designed to assess the efficacy and safety of LY-CoV555 and LY-CoV016 for the treatment of symptomatic COVID-19 in the **outpatient setting**. Across all treatment arms, the trial will enroll an estimated 800 participants.

BLAZE-1: RCT, Phase 2 800 Pts. LY-CoV555 & LY-CoV016

A **phase 3** study for the **prevention** of COVID-19 in residents and staff at long-term care facilities (NCT04497987, **BLAZE-2**) is recently initiated.

BLAZE-2: RCT, Phase 3 initiiert

In addition, LY-CoV555 is being tested in the National Institutes of Health-led **ACTIV-2** and **ACTIV-3** studies of **ambulatory** and **hospitalised** COVID-19 patients.

NIH-Studien: ACTIV-2 and ACTIV-3

To generate additional efficacy and safety data, a pragmatic, open-label study enrolling patients treated with either monotherapy or combination therapy, with a focus on collecting data regarding hospitalizations, deaths and safety, planned to be initiated in October 2020.

pragmatic trial in Planung

On 27 January 2021, **Eli Lilly and Company**, **Vir Biotechnology, Inc.** and **Glaxo Smith Kline plc** announced a collaboration to evaluate a **combination of two COVID-19 therapies** in **low-risk patients with mild to moderate COVID-19**. Lilly has expanded its ongoing **BLAZE-4** trial to evaluate the administration of **bamlanivimab (LY-CoV555) 700mg** with **VIR-7831** (**dual-action monoclonal antibody**, also known as **GSK4182136**) **500mg**, two neutralizing antibodies that bind to different epitopes of the SARS-CoV-2 spike protein [174].

EliLilly Kooperation mit GSK zu Kombinations-therapie Bamlanivimab + VIR-7831

bei milder/moderater Erkrankung

New SARS-CoV-2 Variants

Bamlanivimab monotherapy

In the FDA new revision related to bamlanivimab monotherapy and new variants, published on March 2021, there is a potential risk of treatment failure due to the development of viral SARS-CoV-2 variants that are resistant to bamlanivimab. Prescribing healthcare providers should consider the prevalence of bamlanivimab resistance variants in their area, where data are available, when considering treatment options [175]. Non-clinical studies using serial passage of SARS-CoV-2 and directed evolution of the spike protein identified amino acid substitutions E484D/K/Q, F490S, Q493R and S494P, in the spike protein receptor binding domain. These substitutions conferred reduced susceptibility to bamlanivimab as determined in neutralization assays using SARS-CoV-2 (F490S and S494P: >485-fold and >71-fold reduction, respectively), vesicular stomatitis virus-based pseudovirus expressing spike protein with variant substitutions (all variants >100-fold reduction), and spike protein binding assessment if pseudovirus assessment was unsuccessful (E484D). Evaluation of susceptibility of variants identified through global surveillance and in subjects treated with bamlanivimab is ongoing. Pseudovirus harboring the E484K substitution had reduced susceptibility to bamlanivimab; this substitution is found in several lineages, including B.1.351 (South Africa origin), P.1 (Brazil origin) and B.1.526 (New York origin). In addition, pseudoviruses with the spike protein and concurrent spike substitutions present in the South African B.1.351 origin variant lineage (K417N + E484K + N501Y), and the Brazil origin P.1 variant lineage (K417T + E484K + N501Y) exhibited reduced susceptibility to bamlanivimab. Pseudovirus harboring the L452R and the spike protein from the California origin variant lineage B.1.427/B.1.429 exhibited reduced susceptibility to bamlanivimab. Bamlanivimab retained activity against

FDA Analyse zur Wirksamkeit bei unterschiedlichen Mutationen

Risiko für Resistenzen unter Beobachtung

pseudovirus expressing del69-70 + N501Y spike substitutions found in the UK origin B.1.1.7 variant lineage (Table 3.13-2)

Table 3.13-2. Pseudovirus neutralization data for SARS-CoV-2 variant substitutions with bamlanivimab alone

Lineage with Spike Protein Substitution	Key substitutions tested [a]	Fold reduction in susceptibility
B.1.1.7 (UK origin)	N501Y	no change [b]
B.1.351 (South Africa origin)	E484K	>2,360 [c]
P.1 (Brazil origin)	E484K	>2,360 [c]
B.1.427/B.1.429 (California origin)	L452R	>1,020 [c]
B.1.526 (New York origin) [d]	E484K	>2,360 [c]

a For variants with more than one substitution of concern, only the one with the greatest impact on activity is listed.
b No change: <5-fold reduction in susceptibility
c No activity was observed at the highest concentration tested. Bamlanivimab alone is unlikely to be active against variants from this lineage.
d Not all isolates of the New York lineage harbor the E484K substitution (as of February 2021).

Source: [175]

Bamlanivimab plus etesevimab combination

FDA Analyse zur Wirksamkeit bei unterschiedlichen Mutationen

In the FDA new revision related to bamlanivimab plus etesevimab combination and new variants, published on March 2021, resistant variants were identified using directed evolution of the spike protein and serial passage in cell culture of SARS-CoV-2 in the presence of bamlanivimab or etesevimab individually. Resistant variants were not identified when bamlanivimab and etesevimab were tested together using the same methodology. Viral variants identified in these studies that had reduced susceptibility to bamlanivimab included spike protein amino acid substitutions E484D/K/Q, F490S, Q493R, and S494P, and variants that had reduced susceptibility to etesevimab included substitutions K417N, D420N, and N460K/S/T. Neutralization assays using SARS-CoV-2, vesicular stomatitis virus-based pseudovirus, or binding assessment if pseudovirus construction was unsuccessful (E484D), confirmed reductions in susceptibility to the selecting antibody. Retention of susceptibility to the other antibody alone was observed, with the exception of the Q493R substitution. All variants maintained susceptibility to bamlanivimab and etesevimab together, with the exception of those with E484K, E484Q, and Q493R substitutions, which had reduced susceptibility of 17-fold, 22-fold, and >100-fold, respectively in a pseudovirus assay.

keine Resistenzen bei Kombinationstherapie identifiziert, nur bei Monoterapie

Risiko für Resistenzen unter Beobachtung

Evaluation of susceptibility of variants identified through global surveillance in subjects treated with bamlanivimab and etesevimab is ongoing. Pseudoviral evaluation of amino acid substitutions identified in global surveillance showed that the V483A substitution reduced susceptibility to bamlanivimab 48-fold, but activity was maintained with etesevimab, and with bamlanivimab and etesevimab together. N501Y and N501T substitutions reduced susceptibility to etesevimab approximately 5-fold and 20-fold, respectively. Activity against variants with N501Y or N501T substitutions was maintained with bamlanivimab alone, and with bamlanivimab and etesevimab together. Bamlanivimab alone and bamlanivimab and etesevimab together retained activity against pseudovirus expressing del69-70 + N501Y found in the B.1.1.7 variant (UK origin). Pseudovirus expressing spike protein from the B.1.351 lineage (South Africa origin) or substitutions K417N + E484K + N501Y found in this lineage had reduced susceptibility to

bamlanivimab and etesevimab together of >45-fold, and pseudovirus expressing K417T + E484K + N501Y found in the P.1 lineage (Brazil origin) had reduced susceptibility to bamlanivimab and etesevimab together of >511-fold. Pseudovirus expressing spike protein from the B.1.427/B.1.429 lineages (California origin), or the L452R substitution found in this lineage, had reduced susceptibility to bamlanivimab and etesevimab together of 7.7-fold or 7.4-fold, respectively (Table 3.13-3…) [176].

Table 3.13-3: Pseudovirus neutralization data for SARS-CoV-2 variant substitutions with bamlanivimab plus etesevimab together (1:2 molar ration)

Lineage with Spike Protein Substitution	Key substitutions tested [a]	Fold reduction in susceptibility
B.1.1.7 (UK origin)	N501Y	no change [b]
B.1.351 (South Africa origin)	K417N + E484K + N501Y	>45 [c]
P.1 (Brazil origin)	K417N + E484K + N501Y	>511 [c]
B.1.427/B.1.429 (California origin)	L452R	7.4
B.1.526 (New York origin) [d]	E484K	17

a For variants with more than one substitution of concern, only the one with the greatest impact on activity is listed.
b No change: <5-fold reduction in susceptibility
c No activity was observed at the highest concentration tested. Bamlanivimab and etesevimab together are unlikely to be active against variants from this lineage.
d Not all isolates of the New York lineage harbor the E484K substitution (as of February 2021).

Source: [176]

US COVID-19 Treatment Guidelines (update April 8, 2021)

US COVID-19 Treatment Guidelines Panel

Empfehlung für Antikörper Kombinationstherapien

Bamlanivimab + Etesevimab oder Casirivimab + Imdevimab

keine Vergleichsstudien

Empfehlung gegen Antikörper Monotherapie Bamlanivimab

Empfehlung gegen Antikörpertherapie bei hospitalisierten Patient*innen

- The **US COVID-19 Treatment Guidelines Panel** recommends using one of the following combination anti-SARS-CoV-2 monoclonal antibodies to treat outpatients with mild to moderate COVID-19 who are at high risk of clinical progression, as defined by the EUA criteria (listed in alphabetical order):
  - **Bamlanivimab 700 mg plus etesevimab 1,400 mg (AIIa);** *or*
  - **Casirivimab 1,200 mg plus imdevimab 1,200 mg (AIIa).**
- Treatment should be started as soon as possible after the patient receives a positive result on a SARS-CoV-2 antigen or nucleic acid amplification test (NAAT) and within 10 days of symptom onset.
- There are no comparative data to determine whether there are differences in clinical efficacy or safety between bamlanivimab plus etesevimab and casirivimab plus imdevimab.
  - There are SARS-CoV-2 variants, particularly those that contain the mutation E484K, that reduce the virus' susceptibility to bamlanivimab and, to a lesser extent, casirivimab and etesevimab in vitro; however, the clinical impact of these mutations is not known.
  - In regions where SARS-CoV-2 variants with reduced in vitro susceptibility to bamlanivimab plus etesevimab are common, some Panel members would preferentially use casirivimab plus imdevimab while acknowledging that it is not known whether in vitro susceptibility data correlate with clinical outcomes.
- Because clinical outcome data are limited and there are concerns regarding decreased susceptibility of variants, the Panel **recommends against** the use of **bamlanivimab monotherapy (AIII).**

  - If combination products are not available, the use of bamlanivimab monotherapy can be considered for people who meet the EUA criteria on a case-by-case basis.
- The Panel **recommends against** the use of **anti-SARS-CoV-2 monoclonal antibodies** for patients who are hospitalized because of COVID-19, except in a clinical trial **(AIIa).** However, their use should be considered for persons with mild to moderate COVID-19 who are hospitalized for a reason other than COVID-19 but who otherwise meet the EUA criteria [151].

Results of publications

Final results of the **phase 2 portion of BLAZE-1**, randomised, double-blind, placebo-controlled trial **(NCT04427501)** were published by Gottlieb et al. 2021 [177]. The BLAZE-1 study is a randomized phase 2/3 trial at 49 US centers including **ambulatory patients** (n = 613) who tested positive for SARS-CoV-2 infection and had 1 or more **mild to moderate** COVID-19 symptoms. Patients who received **bamlanivimab** (LY-CoV555) **monotherapy** or placebo were enrolled first followed by patients who received **bamlanivimab** (LY-CoV555) **and etesevimab** (LY-CoV016) **combination** or **placebo**. Patients were randomized to receive a single infusion of bamlanivimab (700 mg [n=101], 2800 mg [n=107], or 7000 mg [n=101]), the combination treatment (2800mg of bamlanivimab and 2800 mg of etesevimab [n=112]), or placebo (n=156). The primary end point was change in SARS-CoV-2 log viral load at day 11 (±4 days). Nine prespecified secondary outcome measures were evaluated with comparisons between each treatment group and placebo, and included 3 other measures of viral load, 5 on symptoms, and 1 measure of clinical outcome (the proportion of patients with a COVID-19–related hospitalization, an emergency department [ED] visit, or death at day 29).

Phase 2/ 3 RCT
BLAZE-1
613 Patient*innen
milde/ moderate Erkrankung

Monotherapie vs. Kombinationstherapie mit Etesevimab

Ergebnisse von Phase 2 Kohorte

Data on high certainty of evidence, related to effectiveness and safety of bamlanivimab monotherapy and bamlanivimab + etesevimab compared to placebo and each other, reported in this RCT, prepared by Cruciani et al. [178-181], can be found in the Summary of Findings 3.13-4 continued. In summary, based on the final results of the phase 2 portion of one RCT in **outpatients** with recently diagnosed mild or moderate Covid-19, no deaths occurred in bamlanivimab, bamlanivimab + etesevimab combination and placebo group (high certainty of evidence). Bamlanivimab + etesevimab treatment compared to placebo significantly reduces Covid-19–related hospitalisation or visit to an emergency department at day 29, but bamlanivimab monotherapy does not. The change in mean total symptom score from baseline to day 11 was statistically significantly different for the 700 mg monotherapy group and for the bamlanivimab + etesevimab combination group.

kein Unterschied bei Mortalität

signifikante Unterschiede bei Hospitalisierung, Besuch in Notfallambulanz unter Kombinationstherapie, aber nicht Monotherapie

besere Symtomkontrolle aber unter beiden Interventionen

Bamlanivimab and bamlanivimab + etesevimab treatment compared to placebo does not increase number of patients with adverse events or number of serious adverse events (high certainty of evidence). The same is true for bamlanivimab compared to bamlanivimab + etesevimab treatment. Bamlanivimab monotherapy or bamlanivimab + etesevimab treatment, compared to placebo, does not accelerate the natural decline in viral load over time (high certainty of evidence). The same is true for bamlanivimab compared to bamlanivimab + etesevimab treatment.

aber: keine raschere Viruslastreduktion

gleiche Nebenwirkungen

On January 26, 2021 Eli Lilly and Company announced **unpublished results from phase 3 BLAZE-1 RCT** on the combination therapy arms enrolled mild to moderate, recently diagnosed COVID-19 patients who are at high risk for progressing to severe COVID-19 and/or hospitalization, studying bamlanivimab 2800 mg plus etesevimab 2800 mg versus placebo. The primary outcome measure for the phase 3 portion of the BLAZE-1 trial was the percentage of participants who experience COVID-related hospitalizations or death from any cause by day 29. The key secondary endpoints were change from baseline to day 7 in SARS-CoV-2 viral load, persistently high SARS-CoV2 viral load on day 7, time to sustained symptom resolution, and COVID-related hospitalization, ER visit or death from any cause from baseline by day 29. Additional endpoints include change from baseline in viral load at other time points, symptom improvement, symptom resolution, as well as safety.

Phase 2/ 3 RCT
BLAZE-1
1.035 Patient*innen
Ergebnisse von Phase 3 Kohorte
milde/ moderate Erkrankung, aber Risiko progredienter Erkrankung

Bamlanivimab (LY-CoV555) 2800 mg and etesevimab (LY-CoV016) 2800 mg together significantly reduced COVID-19-related hospitalisations and deaths in high-risk patients recently diagnosed with COVID-19. Across 1,035 patients, there were 11 events (2.1 percent) in patients taking therapy and 36 events (7.0 percent) in patients taking placebo, representing a 70 percent risk reduction (p=0.0004). There were 10 deaths total, all of which occurred in patients taking placebo, and no deaths in patients taking bamlanivimab and etesevimab together. Bamlanivimab and etesevimab together also demonstrated statistically significant improvements on all key secondary endpoints, providing strong evidence that the therapy reduced viral load and accelerated symptom resolution. The safety profile of bamlanivimab and etesevimab together was consistent with observations from other phase 1, phase 2 and phase 3 trials evaluating these antibodies. Serious adverse events were reported at a similar frequency in the bamlanivimab and etesevimab together and placebo groups.

signifikante Reduktion von Hospitalisierung und Mortalität

von 1.035 Pts
2,1% Ereignisse in Interventionsgruppe,
7% in Kontrollgruppe

Todesfälle nur in Plazebogruppe

gleiche Nebenwirkungen

On March 10, 2021 Eli Lilly and Company announced new data from the **BLAZE-1 phase 3 study**, demonstrating bamlanivimab (LY-CoV555) 700 mg and etesevimab (LY-CoV016) 1400 mg together significantly reduced COVID-19 related hospitalizations and deaths ("events") in high-risk patients recently diagnosed with COVID-19.

Phase 3 RCT BLAZE-1
769 Pts
milde/ moderate Erkrankung
Kombinationstherapie

This new phase 3 cohort of BLAZE-1 included 769 high-risk patients, aged 12 and older with mild to moderate COVID-19 (therapy: n=511; placebo: n=258). There were four events in patients taking bamlanivimab with etesevimab and 15 events in patients taking placebo, representing an 87 percent risk reduction (p<0.0001). Bamlanivimab and etesevimab together also demonstrated statistically significant improvements on key secondary endpoints. These results are consistent with those seen in other data sets from BLAZE-1: in the previous phase 3 cohort, bamlanivimab 2800 mg with etesevimab 2800 mg reduced the risk of hospitalizations and deaths by 70 percent and in the phase 2 cohort, bamlanivimab alone reduced the risk of hospitalizations and ER visits by approximately 70 percent. The viral load reductions were also consistent with what was observed in the previous phase 3 cohort of the study. In this new phase 3 cohort, there were four deaths total, all of which were deemed related to COVID-19 and all of which occurred inpatients taking placebo; no deaths occurred in patients receiving treatment with bamlanivimab and etesevimab together. Across the two phase 3 cohorts of the study that have been analyzed to date, there have been no deaths in patients receiving treatment withbamlanivimab and etesevimab together, and 14 deaths in patients receiving placebo, 13 of which were deemed COVID-19 related. In this data set, the safety profile of bamlanivimab and etesevimab together was consistent with observations from other phase 1, phase 2 and phase 3 trials evaluating these antibodies, https://investor.lilly.com/news-

70%ige Reduktion der Hospitalisierungen und Notfallambulanz-Besuche

releases/news-release-details/lillys-bamlanivimab-and-etesevimab-together-reduced..

Additionally, initial results from the **ongoing BLAZE-4 trial** (**NCT04634409**) provide viral load and pharmacodynamic/pharmacokinetic data which demonstrated lower doses, including bamlanivimab 700 mg and etesevimab 1400 mg together, are similar to bamlanivimab 2800 mg and etesevimab 2800 mg together [182].

BLAZE-4 laufend
Dosisfindung

On March 29, 2021 Eli Lilly and Company, Vir Biotechnology, Inc. and GlaxoSmithKline plc announced data from the **expanded phase 2 BLAZE-4** trial studying **low-risk adult patients** with **mild to moderate COVID-19**. Results showed that investigational **bamlanivimab** (LY-CoV555) **700 mg co-administered with VIR-7831** (also known as GSK4182136) **500 mg** demonstrated a 70 percent ($p<0.001$) relative reduction in persistently high viral load (> 5.27; cycle threshold value < 27.5) at day 7 compared to placebo, meeting the primary endpoint. Bamlanivimab administered with VIR-7831 demonstrated a statistically significant reduction compared to placebo in the key virologic secondary endpoints of mean change from baseline to days 3, 5 and 7 in SARS-CoV-2 viral load. There were no events for the secondary endpoint of COVID-19 related hospitalization or death by day 29 in either study arm. One patient (in the treatment arm) visited the emergency room for COVID-19 related symptoms. No serious adverse events were seen with co-administration of bamlanivimab and VIR-7831. Bamlanivimab and VIR-7831 bind to different regions of the spike protein of SARS-CoV-2. Preclinical data suggest the administration of these two investigational antibodies together may provide protection against current variants of SARS-CoV-2 that are resistant to bamlanivimab. [183]

Pressemeldung:

Phase 2 BLAZE-4
Kombinationstherapie mit VIR-7831
in mild/ moderater Erkrankung

-70% Viruslastreduktion

Lundgren et al. 2020 (**ACTIV-3/TICO** LY-CoV555 Study group) published **preliminary** negative results from RCT (**NCT04501978**) compared LY-CoV555 with placebo in **hospitalised patients** who had Covid-19 without end-organ failure [184] . In addition, all the patients received high-quality supportive care as background therapy, including the antiviral drug remdesivir (95% of patients) and, when indicated, supplemental oxygen and glucocorticoids. The data and safety monitoring board recommended stopping enrollment for futility after 314 patients (163 in the LY-CoV555 group and 151 in the placebo group) had undergone randomization and infusion.

RCT mit hospitalisierten Pts. mit Organversagen

Kombinationstherapie Bamlanivimab + Remdesivir

kein Unterschied/ keine Wirksamkeit

Data on high certainty of evidence, related to effectiveness and safety of bamlanivimab reported in this one RCT mentioned above, prepared by Cruciani et al. [185, 186], can be found in the Summary of Findings 3.13 -2. Based on the interim results from one RCT with high certainty of evidence, in **hospitalised** patients, bamlanivimab compared to standard treatment does not reduce all-cause mortality, does not increase the number of patients with AEs and SAEs, and does not increase the number of patients discharged.

Daten zu hospitalisierten Patient*innen

keine Reduktion der Gesamtmortalität

Table 3.13.-4: Summary of findings (SoF) table for published RCTs related to effectiveness and safety of bamlanivimab monotherapy (all doses) compared to placebo and bamlanivimab+etesevimab combination treatment – OUTPATIENT (1 RCT: Gottlieb 2021)

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Number of participants (studies)	Certainty of evidence	Comments
	Risk with Placebo **Risk with Bamlanivimab + etesevimab**	**Risk with Bamlanivimab** (previously neutralizing antibody LY-CoV555)				
All-cause mortality						
	No deaths occured	No deaths occured	No deaths occured	No deaths occured	⊕⊕⊕⊕ HIGH	No deaths occurred
	No deaths occured	No deaths occured	No deaths occured	No deaths occured	⊕⊕⊕⊕ HIGH	No deaths occurred
Number of patients with any adverse events						
	269 per 1000	242 per 1000	**RR 0.90** (0.65 to 1.25)	465 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI)** **27 fewer per 1.000** (from 94 fewer to 67 more)
	170 per 1000	243 per 1000	**RR 1.43** (0.91 to 2.25)	421 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI)** **73 more per 1.000** (from 15 fewer to 212 more)
Number of patients with serious adverse events						
	60 per 1000	10 per 1000	**RR 0.17** (0.01 to 4.12)	465 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI)** **5 fewer per 1.000** (from 6 fewer to 20 more)
	90 per 1000	11 per 1000	**RR 0.12** (0.00 to 2.96)	421 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**8 fewer per 1.000** (from -- to 17 more)
SARS-CoV-2 clearance						
	368 per 1000	390 per 1000	**RR 1.06** (0.83 to 1.37)	461 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI)** **22 more per 1.000** (from 63 fewer to 136 more)
	367 per 1000	392 per 1000	**RR 1.07** (0.80 to 1.42)	418 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI)** **26 more per 1.000** (from 73 fewer to 154 more)

Source: Cruciani F, De Crescenzo F, Vecchi S, Saulle R, Mitrova Z, Amato L, Davoli M. Should LY-CoV555 antibody monotherapy compared to LY-CoV555 antibody + Etesevimab be used for COVID-19 patients? 2021.

[a] ref Gottlieb et al

Abbreviations: CI=Confidence interval; RR=Risk ratio

Table 3.13-4 continued: Summary of findings (SoF) table for published RCTs related to effectiveness and safety of bamlanivimab + etesevimab combination compared to placebo – OUTPATIENT (1 RCT: Gottlieb 2021)

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Number of participants (studies)	Certainty of evidence	Comments
	Risk with Placebo	Risk with Bamlanivimab + etesevimab				
All-cause mortality	No deaths occured	No deaths occured	No deaths occured	No deaths occured	⊕⊕⊕⊕ HIGH	No deaths occurred
Number of patients with any adverse events	269 per 1000	170 per 1000	**RR 0.63** (0.39 to 1.02)	268 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI) 100 fewer per 1.000** (from 164 fewer to 5 more)
Number of patients with serious adverse events	60 per 1000	83 per 1000	**RR 1.39** (0.09 to 22.03)	268 (1 RCT) [a]	⊕⊕⊕◯ MODERATE	**Absolute effect (95% CI) 2 more per 1.000** (from 6 fewer to 135 more)
SARS-CoV-2 clearance	368 per 1000	368 per 1000	**RR 1.00** (0.72 to 1.38)	261 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI) 0 fewer per 1.000** (from 103 fewer to 140 more)

Source: Ref Cruciani F, De Crescenzo F, Vecchi S, Saulle R, Mitrova Z, Amato L, Davoli M. Should LY-CoV555 antibody+ Etesevimab compared to Placebo be used for COVID-19 patients? 2021.;
[a] ref Gottlieb et al

Table 3.13-5: Summary of findings (SoF) table for published RCTs related to effectiveness and safety of bamlanivimab compared to standard treatment/placebo – HOSPITALISED (1 RCT: Lundgren et al. 2020)

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Number of participants (studies)	Certainty of evidence	Comments
	Risk with Standard treatment/Placebo	Risk with Bamlanivimab (previously neutralizing antibody LY-CoV555)				
All-cause mortality	32 per 1000	53 per 1000	**RR 1.67** (0.57 to 4.88)	326 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI) 21 more per 1.000** (from 14 fewer to 124 more)
Number of patients with adverse events	172 per 1000	219 per 1000	**RR 1.27** (0.82 to 1.99)	326 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI) 46 more per 1.000** (from 31 fewer to 170 more)
Number of patients with serious adverse events	32 per 1000	30 per 1000	**RR 0.93** (0.27 to 3.15)	326 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI) 2 fewer per 1.000** (from 23 fewer to 68 more)
Number of patients discharged	866 per 1000	846 per 1000	**RR 0.98** (0.89 to 1.07)	326 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	**Absolute effect (95% CI) 17 fewer per 1.000** (from 95 fewer to 61 more)

Source: Ref Cruciani F, De Crescenzo F, Vecchi S, Saulle R, Mitrova Z, Amato L, Davoli M. Should LY-CoV555 antibody compared to Standard treatment be used for hospitalised COVID-19 patients? 2020.

[a] ref Lundgren et al 2020 (ACTIV-3/TICO LY-CoV555 Study group)
Abbreviations: CI=Confidence interval; RR=Risk ratio

Regulatory update:

On November 9, 2020, the **U.S. Food and Drug Administration** issued an **Emergency Use Authorization (EUA)** for the investigational monoclonal antibody therapy **bamlanivimab (previously LY-CoV555)** for the treatment of **mild-to-moderate COVID-19** in adult and pediatric patients. Bamlanivimab is authorized for patients with positive results of direct SARS-CoV-2 viral testing who are **12 years of age and older** weighing at least 40 kilograms (about 88 pounds), and who are **at high risk for progressing to severe COVID-19 and/or hospitalisation**. This includes those who are 65 years of age or older, or who have certain chronic medical conditions, https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-monoclonal-antibody-treatment-covid-19. Bamlanivimab is not authorized for patients who are hospitalised due to COVID-19 or require oxygen therapy due to COVID-19. A benefit of bamlanivimab treatment has not been shown in patients hospitalised due to COVID-19. Monoclonal antibodies, such as bamlanivimab, may be associated with worse clinical outcomes when administered to hospitalised patients with COVID-19 requiring high flow oxygen or mechanical ventilation.

November: FDA EUA für bamlanivimab

für ambulante Pts mit Risiko auf Verschlechterung

nicht für bereits hospitalisierte Pts.

On February 9, 2021 the **FDA** issued an **EUA** for **bamlanivimab and etesevimab administered together** for the treatment of **mild to moderate COVID-19** in adults and pediatric patients (12 years of age or older weighing at least 40 kilograms [about 88 pounds]) who test positive for SARS-CoV-2 and who are at high risk for progressing to severe COVID-19. The authorized use includes treatment for those who are 65 years of age or older or who have certain chronic medical conditions. In a clinical trial of patients with COVID-19 at high risk for disease progression, a single intravenous infusion of bamlanivimab and etesevimab administered together significantly reduced COVID-19-related hospitalisation and death during 29 days of follow-up compared to placebo. The safety and effectiveness of this investigational therapy for use in the treatment of COVID-19 continue to be evaluated. Bamlanivimab and etesevimab are not authorized for patients who are hospitalised due to COVID-19 or require oxygen therapy due to COVID-19. Treatment with bamlanivimab and etesevimab has not been studied in patients hospitalised due to COVID-19. Monoclonal antibodies, such as bamlanivimab and etesevimab, may be associated with worse clinical outcomes when administered to hospitalised patients with COVID-19 requiring high flow oxygen or mechanical ventilation, https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-monoclonal-antibodies-treatment-covid-19-0.

Feb 2021: Zulassung (EUA) durch FDA

Kombinationstherapie bei milder/ moderater Erkrankung und Risko für prtogrediente Erkrankung

On **March 5, 2021 EMA** stated that the CHMP has completed its review started in February 2021[187], to provide a **harmonised scientific opinion** at EU level to support national decision making on the possible use of the antibodies **before a formal authorisation is issued**. The Agency concluded that **bamlanivimab monotherapy** and **bamlanivimab and etesevimab combination** can be used together to treat confirmed COVID-19 in patients who **do not require supplemental oxygen and who are at high risk of their COVID-19 disease becoming severe** [188, 189]. Risk factors may include but are not limited to: advanced age; obesity; cardiovascular disease, including hypertension; chronic lung disease, including asthma; type 1 or type 2 diabetes mellitus; chronic kidney disease, including those on dialysis; chronic liver disease; immunosuppressed, based on prescriber's assessment. Examples include: cancer treatment, bone marrow or organ transplantation, immune deficiencies, HIV (if poorly controlled or evidence of AIDS), sickle cell anemia, thalassemia, and prolonged use of immune-weakening medications.

März 2021

EMA: Bamlanivimab kann sowohl als Monotherapie wie auch als Kombinations-therapie mit Etesevimab eingesetzt werden

bei Pts mit bestätigtem Covid-19, nicht beatmungspflichtig, aber hohem Risiko auf Fortschreiten auf schweren Verlauf der Erkrankung

On **March 11, 2021** EMA's CHMP has started a '**rolling review**' of data on the antibodies bamlanivimab and etesemivab to be used in combination for the treatment of COVID-19. The review will also look at bamlanivimab used alone. The rolling review will continue until enough evidence is available to support formal marketing authorisation applications, https://www.ema.europa.eu/en/news/ema-starts-rolling-review-eli-lilly-antibodies-bamlanivimab-etesemivab-covid-19.

3.13.3 AZD7442 - combination of two monoclonal antibodies (AZD8895 + AZD1061)

AZD7442 Kombination aus 2 monoklonalen Antikörpern Vanderbilt University/ AstraZeneca

AZD7442 is a combination of two mAbs (AZD8895 + AZD1061) derived from convalescent patients with SARS-CoV-2 infection. Discovered by Vanderbilt University Medical Center and licensed to AstraZeneca in June 2020, the mAbs were optimised by AstraZeneca with half-life extension and reduced Fc receptor binding. The half-life extended mAbs should afford at least six months of protection from COVID-19.

Phase 1
Ende Sept 2021

NCT04507256 is a **phase 1**, first time in human, randomised, double-blind, placebo-controlled, and dose escalation study that aims to evaluate the safety, tolerability and pharmacokinetics of AZD7442 in healthy participants. Estimated study completion date is September 2021.

Phase 2 & 3 laufend

Larger late-stage **phase 2** and **phase 3** (NCT047233394, in outpatient adults) trials are ongoing to evaluate its efficacy as a potential preventative and treatment approach against COVID-19, https://www.astrazeneca.com/media-centre/press-releases/2020/phase-1-clinical-trial-initiated-for-monoclonal-antibody-combination-for-the-prevention-and-treatment-of-covid-19.html.

Feb 2021: Phase 3 RCT begonnen

Studie ist Arm in ACTIV-3

An international randomized, controlled **phase 3** clinical trial has begun in February 2021, evaluating the safety and efficacy of AZD7442 for treating people hospitalised with COVID-19. The trial, **part of a master protocol - ACTIV-3**, has an adaptive design allowing investigators to add new sub-studies of additional investigational agents. ACTIV-3 is sponsored by the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health, https://www.nih.gov/news-events/news-releases/clinical-trial-hospitalized-covid-19-patients-evaluates-long-acting-antibody-therapy.

3.13.4 VIR-7831 monoclonal antibody

monoklonaler Antikörper

VIR-7831 (Vir Biotechnology company) is a **dual-action monoclonal antibody** that was selected for clinical development based on its potential to both block viral entry into healthy cells and clear infected cells, as well as its potential to provide a high barrier to resistance. It has shown the ability to neutralize SARS-CoV-2 live virus in vitro. The antibody binds to an epitope on SARS-CoV-2 shared with SARS-CoV-1, indicating that the epitope is highly conserved, which may make it more difficult to escape mutants to develop. VIR-7832 has been engineered with the potential to enhance lung bioavailability, have an extended half-life, and function as a **therapeutic** and/or prophylactic T cell vaccine.

A **phase 2/3 COMET-ICE** (COVID-19 Monoclonal antibody Effcacy Trial - Intent to Care Early) trial was launched on September 10, 2020, in which subjects with COVID-19 will receive VIR-7831 or placebo and be assessed for safety, tolerability, efficacy, and pharmacokinetics. The **phase 3 part** of the COMET-ICE trial is assessing the safety and effacy of a single intravenous (IV) infusion of VIR-7831 or placebo in approximately 1,300 **non-hospitalised** participants globally. The primary efficacy endpoint is the proportion of adults who have progression of COVID-19 as defined by the need for hospitalization or death within 29 days of randomization. The COMET clinical development program for VIR-7831 also includes a planned phase 3 trial for the prevention of symptomatic infection.

Phase 2/3 im Sept 2020 begonnen
COMET-ICE
1.300 Patient*innen nicht-hospitalisiert

Endpunkt: Verhinderung der Progression

On March 10, 2021 Vir Biotechnology, Inc. and GlaxoSmithKline plc **announced** that an Independent Data Monitoring Committee (IDMC) recommended that the phase 3 COMET-ICE be stopped for enrollment due to evidence of profound efficacy. The IDMC recommendation was based on an **interim analysis** of data from 583 patients enrolled in the COMET-ICE trial, which demonstrated an **85% (p=0.002) reduction in hospitalisation or death in patients receiving VIR-7831 as monotherapy compared to placebo**, the primary endpoint of the trial. VIR-7831 was well tolerated. As the trial remains ongoing and blinded with patients continuing to be followed for 24 weeks, additional results, including epidemiology and virology data, will be forthcoming once the trial is completed. Based on these results, Vir and GSK plan to submit an Emergency Use Authorization (EUA) application to the FDA and for authorizations in other countries, https://www.globenewswire.com/news-release/2021/03/11/2190921/0/en/Vir-Biotechnology-and-GSK-Announce-VIR-7831-Reduces-Hospitalization-and-Risk-of-Death-in-Early-Treatment-of-Adults-with-COVID-19.html.

März 2021:
COMET-ICE
Zwischenauswertung

Studie wegen positive Ergebnisse angehalten:
85% Reduktion von Hospitaliseirung und Tod

The COMET clinical development programme for VIR-7831 includes two additional trials – one for the treatment of hospitalised patients and another for the prevention of symptomatic infection, https://www.gsk.com/en-gb/media/press-releases/vir-biotechnology-and-gsk-announce-global-expansion-to-phase-3-of-comet-ice-study-evaluating-vir-7831-for-the-treatment-of-covid-19/.

weitere Studien:
Prävention symptom. Erkrankung hospitalisierte Pts.

The **ACTIV-3** randomized, placebo-controlled, multicenter, global phase 3 trial investigates the safety and effacy of VIR-7831 in **hospitalised** adults with COVID-19. The trial has closed enrollement in arm examining VIR-7831 on March 1, 2021 (due to futility), following an interim review and recommendations from the independent Data and Safety Monitoring Board (DSMB), https://www.nih.gov/news-events/news-releases/nih-sponsored-activ-3-clinical-trial-closes-enrollment-into-two-sub-studies

ACTIV-3 RCT:
hospitalisierte Pts.
Studie wegen negativer Ergebnisse angehalten

On 27 January 2021, **Eli Lilly and Company**, **Vir Biotechnology, Inc.** and **Glaxo Smith Kline plc** announced a collaboration to evaluate a **combination of two COVID-19 therapies** in **low-risk patients with mild to moderate COVID-19**. On March 29, 2021 Eli Lilly and Company, Vir Biotechnology, Inc. and GlaxoSmithKline plc announced data from this expanded phase 2 BLAZE-4 trial studying **low-risk adult patients** with **mild to moderate COVID-19** [183]. Details could be seen in section on bamlanivimab above.

Pressemeldung:
EliLilly + GSK Kooperation zu Kombinationstherapie bei milder/ moderater Erkrankung

3.13.5 Regdanvimab (CT-P59)

monoklonaler Antikörper

Regdanvimab (from Celltrion Healthcare) is a monoclonal antibody with activity against COVID-19. In pre-clinical data the treatment candidate demonstrated a 100-fold reduction in viral loadof SARS-CoV-2, as well as a reduction in lung inflammation [190].

Phase 1

Results from the global phase 1 clinical trial of CT-P59 demonstrated promising safety, tolerability, antiviral effect and efficacy profile in patients with mild symptoms of COVID-19.

Presseaussendung von Celltrion zu Phase 2/3 positive Ergebnisse

On January 13, 2021 Celltrion Group announced positive efficacy and safety results from global phase 2/3 clinical trial of COVID-19 treatment candidate CT-P59: CT-P59 (40mg/kg) treated patients reported reduced progression rates to severe COVID-19 by 54% for patients with mild-to-moderate symptoms and 68% for moderate patients aged 50 years and over; a significantly shortened time to clinical recovery ranging from 3.4 to 6.4 days quicker compared to placebo and a significant reduction of viral load compared to placebo was reported at Day7 in patients treated with CT-P59. No drug-related serious adverse events reported, https://www.celltrionhealthcare.com/en-us/board/newsdetail?modify_key=433

März 2021: EMA „rolling review" von Regdanvimab für Patient*innen mit Risiko auf progrediente Erkrankung, aber ohne Bedarf nach Beatming

On **March 26, 2021 EMA** announced that the CHMP has completed its ~~a~~ **review** of Celltrion's monoclonal antibody regdanvimab (CT-P59) to **support national authorities** who may decide on the use of this medicine for COVID-19 **prior to authorisation**. EMA concluded that regdanvimab can be used for the treatment of confirmed COVID-19 in adult patients who do not require supplemental oxygen therapy and who are at high risk of progressing to severe COVID-19. Risk factors may include but are not limited to: advanced age; obesity; cardiovascular disease, including hypertension; chronic lung disease, including asthma; type 1 or type 2 diabetes mellitus; chronic kidney disease, including those on dialysis; chronic liver disease; immunosuppressed, based on prescriber's assessment. Examples include: cancer treatment, bone marrow or organ transplantation, immune deficiencies, HIV (if poorly controlled or evidence of AIDS), sickle cell anemia, thalassemia, and prolonged use of immune-weakening medications. The recommended dosage of regdanvimab is a single intravenous (IV) infusion of 40 mg/kg [191, 192].

3.14 Combination therapy – triple combination of interferon beta-1b, lopinavir–ritonavir and ribavirin vs. lopinavir–ritonavir or other triple combination of interferons

Reduktion der Dauer der Virusausscheidung, Symtomverbesserung, Dauer des Krankenhausaufenthalts

kein Unterschied bei AE keine Todesfälle in beiden Gruppen

Hung et al. 2020 [136] present the results of the first randomised controlled trial (**NCT04276688**) on the triple combination of interferon beta-1b, lopinavir–ritonavir, and ribavirin, compared with lopinavir–ritonavir alone, in the treatment of patients admitted to hospital with mild to moderate COVID-19 in Hong-Kong. In this multicentre, prospective, open-label, randomised, phase 2 trial, 127 patients were randomly assigned (2:1) to a 14-day combination of lopinavir 400 mg and ritonavir 100 mg every 12 h, ribavirin 400 mg every 12 h, and three doses of 8 million international units of interferon beta-1b on alternate days (combination group) or to 14 days of lopinavir 400 mg and ritonavir 100 mg every 12 h (control group). Triple therapy was associated with a significant reduction in the duration of viral

shedding (time to negative nasopharyngeal swab 7 days [IQR 5–11] in the combination group vs 12 days [8–15] in the control group; hazard ratio [HR] 4·37 [95% CI 1·86–10·24], p=0.0010), symptom alleviation (time to NEWS2 0 of 4 days [IQR 3–8] vs 8 days [7–9]; HR 3·92 [1·66–9·23], p<0.0001), and duration of hospital stay (9·0 days [7·0–13·0] vs 14·5 days [9·3–16·0]; HR 2·72 [1·2–6·13], p=0.016). There was no mortality in either group. The triple combination also suppressed IL-6 levels. Adverse events included self-limited nausea and diarrhoea with no difference between the two groups. No serious adverse events were reported in the combination group. One patient in the control group had a serious adverse event of impaired hepatic enzymes requiring discontinuation of treatment.

keine weiteren RCTs publiziert

The **Living Systematic Review**, related to this RCT mentioned above, with **Summary of finding table** (https://covid-nma.com/living_data/index.php) is provided in Table 3.14-1.

RCT: 101 Pts

3 Gruppen:
RBV+IFN
LPV/r+IFN
RBV+LPV/r

kein Unterschied

Huang et al. 2020 [137] reported the results from a single-center, randomized, open-labeled, prospective clinical trial (**ChiCTR2000029387**). 101 eligible patients with mild to moderate COVID-19 were randomized into three groups: ribavirin (RBV) plus interferon-a (IFN-a), lopinavir/ritonavir (LPV/r) plus IFN-a, and RBV plus LPV/r plus IFN-a at a 1:1:1 ratio, with a 28-d follow-up. The median interval from baseline to SARS-CoV-2 nucleic acid negativity was 12 d in the LPV/r+IFN-a-treated group, as compared with 13 and 15 d in the RBV+IFN-a-treated group and in the RBV+LPV/r+ IFN-a-treated group, respectively (p=0.23). The proportion of patients with SARS-CoV-2 nucleic acid negativity in the LPV/ r+IFN-a-treated group (61.1%) was higher than the RBV+ IFN-a-treated group (51.5%) and the RBV+LPV/r+IFN-a-treated group (46.9%) at day 14; however, the difference between these groups was calculated to be statistically insignificant. The RBV+LPV/ r+IFN-a-treated group developed a significantly higher incidence of gastrointestinal adverse events than the LPV/r+ IFN-a-treated group and the RBV+ IFN-a-treated group.

RCT (China)
89 Pts.

3 Gruppen
Novaferon (IFN-I)
LPV/r
Novaferon + LPV/r

bessere Ergebnisse in IFN Gruppen

Chinese RCT published by **Zheng et al. 2020** [193, 194] with three arms including 89 patients has evaluated the effect of Novaferon (the pharmaceutical which has similar properties of IFN-I but its antiviral activities has been greatly improved being at least 10 times more potent than human interferon α -2b) (n=30), Lopinavir/Ritonavir (n=29) and Novaferon + Lopinavir/Ritonavir (n=30) in COVID-19 patients. The groups treated with Novaferon alone or in combination with Lopinavir/Ritonavir showed significantly higher clearance rates on day 6 than the group treated with Lopinavir/Ritonavir alone, but the certainty on the evidence is very low. No serious adverse events were reported.

The **Living Systematic Review**, related to this RCT mentioned above, with **Summary of findings table** is provided in Table 3.14-1 continued.

Okt 2020:
preprint RCT
China
94 Pts.

rSIFN vs. IFN-a
beide in Kombination mit
Lopinavir oder
Ritonavir oder
Umifenovir

Li C et al. 2020 [195] reported, as preprint, results from a multicenter, randomized controlled trial (**ChiCTR2000029638**) with aim to evaluate the efficacy and safety of recombinant super-compound interferon versus traditional interferon alpha added to baseline antiviral agents (lopinavir rSIFN-co –ritonavir or umifenovir) for the treatment of moderate-to-severe COVID-19. Recombinant super-compound interferon (rSIFN-co) is a new genetically engineered interferon. Participants received rSIFN-co (12 million international units [IU], twice daily) or interferon alpha (5 million IU, twice daily) nebulization added to baseline antiviral agents for no more than 28 days.

94 patients hospitalized with moderate-to-severe COVID-19 were included in the safety set (46 patients assigned to rSIFN-co group, 48 to interferon alpha group). Individuals in the rSIFN-co group showed shorter time to clinical improvement (11.5 days vs 14.0 days; p = 0.019) as compared to those in the interferon alpha group. The overall rate of clinical improvement on day 28 was much higher in the rSIFN-co group than that in the interferon alpha group (93.5% vs 77.1%; difference, 16.4%; 95% condence interval 3% to 30%). The time to radiological improvement and the time to virus nucleic acid negative conversion were also much shorter in the rSIFN-co group (8.0 days vs 10.0 days, p = 0.002; 7.0 days vs 10.0 days, p = 0.018, respectively). Adverse events were reported in 13 (28.3%) patients in the rSIFN-co group and 18 (37.5%) patients in the interferon alpha group. No patients died during the study.

signifikanter Unterschied zugunsten von rSIFN-co bei klinischer Verbesserung und bei Nebenwirkungen

*Table 3.14-1: Summary of findings table on **triple combination of interferon beta-1b, lopinavir–ritonavir and ribavirin** (1 RCT: Hung) - https://covid-nma.com/living_data/index.php*

Summary of findings:						
Lopinavir + Ritonavir + Ribavirin + Interferon-b-1b compared to Lopinavir + Ritonavir for Mild/Moderate COVID-19						
Patient or population: Mild/Moderate COVID-19 **Setting**: Worldwide **Intervention**: Lopinavir + Ritonavir + Ribavirin + Interferon-b-1b **Comparison**: Lopinavir + Ritonavir						
Outcomes	**Anticipated absolute effects* (95% CI)**		**Relative effect (95% CI)**	**№ of participants (studies)**	**Certainty of the evidence (GRADE)**	**Comments**
	Risk with Lopinavir + Ritonavir	**Risk with Lopinavir + Ritonavir + Ribavirin + Interferon-b-1b**				
Incidence of viral negative conversion D7	902 per 1.000	**875 per 1.000** (767 to 993)	**RR 0.97** (0.85 to 1.10)	127 (1 RCT)	⨁⨁◯◯ LOW [a,b]	
WHO Clinical Progression Score (decrease in 1 point) (i.e., improvement) - not reported	-	-	-	-	-	outcome not yet measured or reported
Admission in ICU or death - not reported	-	-	-	-	-	outcome not yet measured or reported
Incidence of WHO progression score (level 6 or above) - not reported	-	-	-	-	-	outcome not yet measured or reported
Incidence of WHO progression score (level 7 or above) - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D7				127 (1 RCT)	⨁◯◯◯ VERY LOW [a,c]	zero events in both groups

All-cause mortality D14-D28				127 (1 RCT)	⊕◯◯◯ VERY LOW [a,c]	zero events in both groups
Adverse events D14-D28	488 per 1.000	**478 per 1.000** (327 to 698)	**RR 0.98** (0.67 to 1.43)	127 (1 RCT)	⊕⊕⊕◯ MODERATE [d,e]	
Serious adverse events D14-D28	24 per 1.000	**4 per 1.000** (0 to 94)	**RR 0.16** (0.01 to 3.87)	127 (1 RCT)	⊕⊕◯◯ LOW [d,f]	

*__The risk in the intervention group__ (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR:** Risk ratio

GRADE Working Group grades of evidence

High certainty: We are very confident that the true effect lies close to that of the estimate of the effect

Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different

Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect

Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations

a. Indirectness downgraded by 1 level: single study from a single country, therefore results in this population might not be generalizable to other settings

b. Imprecision downgraded by 1 level: low number of participants

c. Imprecision downgraded by 2 levels: no events in both groups and low number of participants

d. Indirectness not downgraded: we presume that adverse event rate is not specific to a certain setting

e. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants

f. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants

Table 3.14-1 continued: Summary of findings tables on ***Novaferon , Lopinavir/Ritonavir and Novaferon + Lopinavir/Ritonavir*** *(1 RCT: Zheng 2020)*

Novaferon versus Lopinavir/Ritonavir

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect (95% CI)	Number of participants (studies)	Certainty of evidence
	Risk with Lopinavir/ Ritonavir	Risk with Novaferon				
SARS-CoV-2 clearance	517 per 1000	567 per 1000	RR 1.10 (0.68 to 1.75)	**52 more per 1000 (from 166 fewer to 388 more)**	59	Very low
Progression of COVID-19 severity	143 per 1000	0 per 1000	RR 0.11 (0.01 to 1.97)	**127 fewer per 1000 (from 141 fewer to 139 more)**	56	Very low
Number with adverse events	138 per 1000	0 per 1000	RR 0.11 (0.01 to 1.91)	**123 fewer per 1000 (from 137 fewer to 126 more)**	59	Very low

Explanations of GRADE: Level of certainty was downgraded of one level for high risk of performance bias and unclear risk of selection bias, and further downgraded of two levels for very few events and small sample size

Novaferon versus Novaferon + Lopinavir/Ritonavir

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect (95% CI)	Number of participants (studies)	Certainty of evidence
	Risk with Novaferon + Lopinavir/ Ritonavir	Risk with Novaferon				
SARS-CoV-2 clearance	700 per 1000	567 per 1000	RR 1.24 (0.84 to 1.83)	**136 more per 1000 (from 91 fewer to 470 more)**	60	Very low
Number with adverse events	100 per 1000	0 per 1000	RR 7.00 (0.38 to 129.93)	**0 fewer per 1000 (from 0 fewer to 0 fewer)**	60	Very low
Number with severe adverse events	Serious adverse events were not reported in either group.					Low
Progression of COVID-19 severity	None of the patients, with a moderate disease severity, had worsened disease.					Low

Explanations of GRADE: For the outcomes "SARS-CoV-2 clearance" and "Number with adverse events", the level of certainty was downgraded of two levels for very few events and small sample size, and further downgraded of one level for small sample size. For the outcomes "Number with severe adverse events" and "Progression of COVID-19 severity", the level of certainty was downgraded of one level for high risk of performance bias and unclear risk of selection bias, and further downgraded of one level for small sample size

Novaferon + Lopinavir/Ritonavir versus Lopinavir/Ritonavir

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect (95% CI)	Number of participants (studies)	Certainty of evidence
	Risk with Lopinavir/ Ritonavir	Risk with Novaferon + Lopinavir/ Ritonavir				
SARS-CoV-2 clearance	517 per 1000	700 per 1000	RR 1.35 (0.89 to 2.06)	**181 more per 1000 (from 57 fewer to 548 more)**	59	Very low
Progression of COVID-19 severity	143 per 1000	0 per 1000	RR 0.11 (0.18 to 2.96)	**127 fewer per 1000 (from 141 fewer to 139 more)**	56	Very low
Number with severe adverse events	138 per 1000	100 per 1000	RR 0.72 (0.18 to 2.96)	**39 fewer per 1000 (from 113 fewer to 270 more)**	59	Low

Explanations of GRADE: For the outcomes "SARS-CoV-2 clearance" and "Number with adverse events", the level of certainty was downgraded of two levels for very few events and small sample size, and further downgraded of one level for small sample size. For the outcomes "Number with severe adverse events" and "Progression of COVID-19 severity", the level of certainty was downgraded of one level for high risk of performance bias and unclear risk of selection bias, and further downgraded of one level for small sample size

Novaferon + Lopinavir/Ritonavir versus Lopinavir/Ritonavir

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect (95% CI)	Number of participants (studies)	Certainty of evidence
	Risk with Lopinavir/ Ritonavir	Risk with Novaferon + Lopinavir/ Ritonavir				
SARS-CoV-2 clearance	517 per 1000	700 per 1000	RR 1.35 (0.89 to 2.06)	**181 more per 1000 (from 57 fewer to 548 more)**	59	Very low
Progression of COVID-19 severity	143 per 1000	0 per 1000	RR 0.11 (0.18 to 2.96)	**127 fewer per 1000 (from 141 fewer to 139 more)**	56	Very low
Number with severe adverse events	138 per 1000	100 per 1000	RR 0.72 (0.18 to 2.96)	**39 fewer per 1000 (from 113 fewer to 270 more)**	59	Low

Explanations of GRADE: For the outcomes "SARS-CoV-2 clearance" and "Progression of COVID-19 severity", the level of certainty was downgraded of two levels for very few events and small sample size, and further downgraded of one level for small sample size. For the outcome "Number with severe adverse events" the level of certainty was downgraded of one level for high risk of performance bias and unclear risk of selection bias, and further downgraded of one level for small sample size.

3.15 Solnatide

About the treatment under consideration

Medikament gegen akutes Atemnotsyndrom

Verabreichung: Inhalation

The therapeutic molecule solnatide (INN) has been designed by APEPTICO (a privately-held biotechnology company from Vienna/Austria) for the therapeutic treatment of patients with Acute Respiratory Distress Syndrome (ARDS) and various forms of life-threatening Pulmonary Oedema (PPO). Solnatide is a synthetic peptide of less than 20 amino acids applied directly in the lower airways in the form of a liquid aerosol, aims to accelerate the dissolution of alveolar oedema and reduce barrier damage caused by Covid-19 in the lungs.

April: BASG, AIFA lassen Solnatide für "Compassionate Use" zu

In April 2020, solnatide has been approved for Compassionate Use by the Austrian Federal Office for Safety in Health Care (BASG) for the treatment of patients infected by the novel coronavirus SARS-CoV-2 and subsequently developing severe pulmonary dysfunction (severe COVID-19), as well as by the Italian Medicines Agency and the Ethics Committee of the National Institute for Infectious Diseases (Lazzaro Spallanzani-Rome), within the compassionate use program of drugs undergoing clinical trials for the treatment of COVID-19 patients suffering from pulmonary oedema and acute respiratory distress syndrome.

EC-Grant seit April für Covid-19

bis Dezember 2021

APEPTICO Forschung und Entwicklung GmbH has signed, together with the "solnatide consortium", the Grant Agreement ID: 101003595 with the European Commission to accelerate the process of making APEPTICO's proprietary investigational medicinal product (IMP) solnatide available for medical treatment of patients severely affected by the novel coronavirus 2019 (SARS-CoV-2) disease, COVID-19; the Grant Agreement was made available via the Horizon2020 programme "Advancing knowledge for the clinical and public health response to the 2019-nCoV epidemic" (https://ec.europa.eu/commission/presscorner/detail/en/ip_20_386). Project started on 1 April 2020 and will end on 31 December 2021. The main goal of the H2020 SOLNATIDE project is to demonstrate safety, tolerability and clinical efficacy of solnatide in treatment of COVID-19 patients.

1 laufender RCT mit 40 moderat bis schwer Covid-19 Erkrankten

One ongoing randomised, double-blind, placebo controlled, parallel assignment trial with aim to assess efficacy and safety of 7 days orally inhaled 100 mg solnatide to treat pulmonary permeability oedema of 40 SARS-Cov-2 positive patients with moderate-to-severe ARDS is registered in EUdraCT register (EudraCT number 2020-001244-26), https://www.clinicaltrialsregister.eu/ctr-search/trial/2020-001244- 26/AT [196].

Withdrawn, suspended or terminated studies

ClinicalTrials.gov & EUdraCT: keine klinischen Studien registriert,

keine Publikation von RCT

No withdrawn, suspended or terminated studies related to solnatide in COVID-19 patients were found in ClinicalTrials.gov and EUdraCT registers [196].

Results of publications

No publications related to the RCTs of solnatide in COVID-19 patients were found [196].

3.16 Umifenovir (Arbidol®)

About the treatment under consideration

Umifenovir (Arbidol), an indole-derivative is a broad-spectrum drug against a wide range of enveloped and non-enveloped viruses: it interacts preferentially with aromatic amino acids, and it affects multiple stages of the virus life cycle, either by direct targeting viral proteins or virus-associated host factors. Umifenovir is currently being investigated as a potential treatment and prophylactic agent for COVID-19 caused by SARS-CoV2 infections in combination with both currently available and investigational HIV therapies (https://pubchem.ncbi.nlm.nih.gov/compound/Arbidol). Its use is only in China and Russia, since not approved by neither the FDA nor the EMA.

antivirales Medikament zugelassen in China, Russland, aber nicht EMA/ FDA

As Wang et al. 2020 recently published, arbidol efficiently inhibited SARS-CoV-2 infection in vitro (it appears to block virus entry by impeding viral attachment and release from the Els) [197].

1 in vitro Publikation

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated studies related to umifenovir were found in ClinicalTrials.gov and EUdraCT registers.

ClinicalTrials.gov & EudraCT: keine Studien registriert

Results of publications

RCT published by **Yueping et al. 2020** (**NCT04252885**) [198] was an exploratory randomised (2:2:1) controlled trial, conducted in China, with the aim to assess the efficacy and safety of lopinavir/ritonavir or arbidol monotherapy in 86 patients with mild/moderate COVID-19. 34 of them assigned to lopinavir/ritonavir; 35 to arbidol and 17 with no antiviral medication as control, with follow-up of 21 days. The rate of positive-to-negative conversion of SARS-CoV-2 nucleic acid, as the primary endpoint, was similar between groups (all $p>0.05$) and there were no differences between groups in the secondary endpoints, the rates of antipyresis, cough alleviation, or improvement of chest CT at days 7 or 14 (all $p>0.05$). At day 7, eight (23.5%) patients in the LPV/r group, 3 (8.6%) in the arbidol group and 2 (11.8%) in the control group showed a deterioration in clinical status from moderate to severe/critical ($p=0.206$). Related to adverse events, 12 (35.3%) patients in the lopinavir/ritonavir group and 5 (14.3%) in the arbidol group experienced adverse events during the follow-up period, and no AE occured in the control group [198].

Yueping (China) RCT, 86 Pts. leichte/ moderate Erkrankung

kein Unterschied zwischen den Gruppen in einigen Surrogatendpunkten

mehr AE

One publication [97] on the completed RCT (**ChiCTR2000030254**) about the efficacy and safety of favipiravir, in comparison with umifenovir, to treat Covid-19 patients was identified; Summary of findings table can be found in Section related to favipiravir.

1 RCT nur im preprint (nicht peer-reviewed)

RCT (**IRCT20180725040596N2**) published by **Nojomi et al. 2020**, as preliminary report in the format of preprints [199], is an open label randomized controlled trial, on effectiveness of umifenovir on 100 patients with COVID-19, assigned randomly to two groups of either hydroxychloroquine just on the 1st day followed by Kaletra (lopinavir-ritonavir) or hydroxychloroquine just on the 1st day followed by umifenovir 7-14 days based on severity of disease. The duration of hospitalization in umifenovir group was less than lopinavir-ritonavir arm significantly (7.2 versus 9.6 days; $p=0.02$). Time to relief fever was similar across two groups (2.7 versus 3.1 days in umifenovir and lopinavir-ritonavir arms respectively). Peripheral oxygen saturation rate was different

Okt 2020: RCT (Iran) 100 Pts.

in Kombinationstherapie kleine Vorteile

after seven days of admission across two groups significantly (94% versus 92% in umifenovir and lopinavir-ritonavir groups respectively) (p=0.02).

November 2020
RCT, 30 Pts. Kirgistan

Yethindra et al. 2020 [200] published results from exploratory randomized controlled study recruited 30 mild and moderate COVID-19 patients in Kyrgyzstan. No patient progressed toward severe and critical illness in either category. Pneumonia was ameliorated in 76.6% (23/30) of the patients, with moderate and potential amelioration in 36.6% and 40% of the patients, respectively. Many patients were observed to have significantly ameliorated pneumonia in the umifenovir category (86.6%, 13 of 15) compared to the control category (66.6%, 10 of 15). In addition, 66.6% of patients in the umifenovir category had potential pneumonia absorption. Only one patient presented with mild side effects in the umifenovir category, while one patient had cephalalgia; notably, no patient experienced severe side effects.

Zusammenfassung von 2 RCTs: unsichere Evidenz zu den Effekten von Umifenovir

The **Living Systematic Review**, related to these two RCTs mentioned above, with Summary of findings table (https://covid-nma.com/living_data/index.php) is presented in Table 3.16-1. According to currently available very low quality of evidence, the evidence is very uncertain about the effect of umifenovir on further outcomes: All-cause mortality D14-D28; WHO progression score level 6 or above D14-28; WHO progression score level 7 or above D14-28; Serious adverse events and Viral negative conversion D7 (RR 0.90, 95% CI 0.44 to 1.84, 1 RCT, very low certainty of evidence).

*Table 3.16-1. Summary of findings table, on **umifenovir vs standard care** (2 RCTs:Yueping, Yethindra)*

Umifenovir compared to Standard Care for Mild/Moderate COVID-19

Patient or population: Mild/Moderate COVID-19
Setting: Worldwide
Intervention: Umifenovir
Comparison: Standard Care

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care	Risk with Umifenovir				
Viral negative conversion D3 - not reported	-	-	-	-	-	outcome not yet measured or reported
Viral negative conversion D7	412 per 1,000	**371 per 1,000** (181 to 756)	**RR 0.90** (0.44 to 1.84)	52 (1 RCT) [b]	⨁◯◯◯ VERY LOW [c,d]	
Clinical improvement D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement D14-D28 - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 6 or above) D7	63 per 1,000	**46 per 1,000** (8 to 248)	**RR 0.73** (0.13 to 3.96)	82 (2 RCTs) [e]	⨁◯◯◯ VERY LOW [d,f,g]	
WHO progression score (level 6 or above) D14-D28	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	30 (1 RCT) [h]	⨁◯◯◯ VERY LOW [c,i]	zero events in both groups
WHO progression score (level 7 or above) D7	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	82 (2 RCTs) [e]	⨁◯◯◯ VERY LOW [g,j,k]	zero events in both groups
WHO progression score (level 7 or above) D14-D28	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	30 (1 RCT) [h]	⨁◯◯◯ VERY LOW [c,j,l]	zero events in both groups
All-cause mortality D7	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	82 (2 RCTs) [e]	⨁◯◯◯ VERY LOW [j,k,m]	zero events in both groups
All-cause mortality D14-D28	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	82 (2 RCTs) [e]	⨁◯◯◯ VERY LOW [j,k,m]	zero events in both groups
Adverse events	0 per 1,000	**0 per 1,000** (0 to 0)	**RR 5.50** (0.32 to 94.06)	52 (1 RCT) [b]	⨁⨁◯◯ LOW [d,n]	zero events in control group
Serious adverse events	0 per 1,000	**0 per 1,000** (0 to 0)	not estimable	82 (2 RCTs) [e]	⨁◯◯◯ VERY LOW [j,k,n]	zero events in both groups

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR**: Risk ratio

GRADE Working Group grades of evidence
High certainty: We are very confident that the true effect lies close to that of the estimate of the effect
Moderate certainty: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
Low certainty: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect
Very low certainty: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty**: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty**: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty**: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last update: November 13, 2020; b. Yueping L, 2020; c. Indirectness downgraded by 1 level: single study from a single institution, therefore results in this population might not be generalizable to other settings; d. Imprecision downgraded by 2 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for harm and very low number of participants; e. Yethindra V, 2020; Yueping L, 2020; f. Risk of bias downgraded by 1 level: some concerns around deviation from intended intervention in both studies, some concerns in one study regarding randomization, outcome measurement, and selection of reported result; g. Indirectness downgraded by 1 level: results are mainly from a single study from a single institution, therefore results in this population might not be generalizable to other settings.; h. Yethindra, 2020; i. Risk of bias downgraded by 1 level: some concerns regarding randomization, deviations from intended intervention, outcome measurement, and selection of the reported results; j. Imprecision downgraded by 2 levels: no events in both groups and very low number of participants; k. Risk of bias downgraded by 1 level: some concerns regarding deviations from intended intervention in both studies, some concerns regarding randomization and selection of reported result in one study; l. Risk of bias downgraded by 1 level: some concerns regarding randomization, deviations from intended intervention, and selection of the reported results; m. Indirectness downgraded by 1 level: results from two single-institution studies, therefore results in the population might not be generalizable to other settings.; n. We presume that the adverse event rates, and the corresponding relative risks, is similar across diverse settings; therefore not downgraded for indirectness

3.17 Dexamethasone and other corticosteroids

About the drug under consideration

Glukokortikoide: entzündungshemmend

Dexamethasone is a long-acting glucocorticoid which is used principally as an anti-inflammatory or immunosuppressant agent. Daily regimen of dexamethasone 6 mg once daily is equivalent to 160 mg of hydrocortisone, 40 mg of prednisone, and 32 mg of methylprednisolone. The proposed mechanism of glucocorticoids in severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) involves the mitigation of an excessive immune response that can lead to acute respiratory distress syndrome (ARDS) and multi-organ failure. ARDS develops in approximately 20% of COVID-19 patients and is linked to multi-organ failure through cytokine release syndrome [201, 202].

nationale, nicht EMA Zulassung, UK: Zulassung im Juni für Covid-19

Dexamethasone is authorised at national level in the EU and is used in a wide range of conditions, including rheumatic problems, skin diseases, severe allergies, asthma and chronic obstructive lung disease. The UK has approved dexamethasone for the treatment of Covid-19 on June 16, 2020 [203].

EMA- CHMP: Zulassungsantrag von Taw Pharma (Sept 2020) im Jänner zurückgezogen

CHMP evaluated Dexamethasone by Taw for a marketing authorisation for the treatment of hospitalised adult patients with COVID-19 [204]. The company withdrew the application on 20 January 2021 because it was unable to remove preservatives from the medicine within the timeframe required by EMA, https://www.ema.europa.eu/en/medicines/human/withdrawn-applications/dexamethasone-taw.

Sept 2020: basierend auf Ergebnissen aus RECOVERY EMA (Rasch-)Zulassung für Pts mit (künstlicher) Beatmung oder Sauerstoff Supplementierung

On September 18, 2020 EMA announced that CHMP has completed its review of results from the RECOVERY dexamethasone study arm. **EMA is endorsing the use of dexamethasone in adults and adolescents (from 12 years of age and weighing at least 40 kg) who require supplemental oxygen therapy.** In all cases, the recommended dose in adults and adolescents is 6 milligrams once a day for up to 10 days. Companies that market dexamethasone medicines can request this new use to be added to their product's license by submitting an application to national medicines agencies or to EMA [205].

Empfehlungen des US COVID-19 Treatment Guidelines Panel: bei künstlich beatmeten Patient*innen , nicht jedoch bei nicht beatmeten Pts.

Based on results of the RECOVERY Trial described below, the **US COVID-19 Treatment Guidelines Panel recommends using dexamethasone** (at a dose of 6 mg per day for up to 10 days) in patients with COVID-19 who are mechanically ventilated **(AI)** and in patients with COVID-19 who require supplemental oxygen but who are not mechanically ventilated **(BI)**. The Panel **recommends against** using dexamethasone in patients with COVID-19 who do not require supplemental oxygen **(AI)** [86]. If dexamethasone is not available, the Panel **recommends using** alternative glucocorticoids such as **prednisone**, **methylprednisolone**, or **hydrocortisone (AIII)** [61]. *For more details, see also section on remdesivir and tocilizumab.*

WHO-Empfehlung für Pts. mit schwerer oder kritischer Erkrankung

The **WHO panel** made two recommendations: a **strong recommendation** (based on moderate certainty evidence) **for systemic** (i.e. intravenous or oral) **corticosteroid therapy** (e.g. 6 mg of dexamethasone orally or intravenously daily or 50 mg of hydrocortisone intravenously every 8 hours) for 7 to 10 days in **patients with severe and critical COVID-19**, and a **conditional recommendation** (based on low certainty evidence) **not to use corticosteroid therapy** in **patients with non-severe COVID-19** [206, 207].

Withdrawn, suspended or terminated studies

Two RCTs were found as terminated: RCT - NCT04327401 (CoDEX), related to dexamethasone, in 299 COVID-19 patients with moderate and severe ARDS in Brazil, the Data Monitoring Committee recommended to stop the trial based on the Recovery Trial results, which was accepted by the CoDEX Steering Committee. NCT04344288 (CORTI-Covid) on prednisone in France, terminated due Competent Authority decision. DEXA-COVID trial (NCT04325061, EudraCT 2020-001278-31) on dexamethasone, is written as suspended (lack of enrollment) in ClinicalTrials.gov, but as ongoing in EUdraCT register. The results of this RCT are not yet published [74]. 1 RCT in US (NCT04360876) is withdrawn because funding not received.

2 abgeschlossene RCTs
1 abgebrochener RCT wegen (besseren Ergebnissen in) Rovery Trial in Brazilien

1 eingestellter RCT – wegen Magel an Rekrutierung

Results of publications

The RCT with the largest number of included COVID-19 patients is RCTs of dexamethasone arm of the **RECOVERY trail** in Covid-19 patients (**NCT04381936, EudraCT 2020-001113-21**) [208]. The primary outcome was all-cause mortality within 28 days after randomization; further analyses were specified at 6 months.

größter RCT: RECOVERY

2.104 Pts

Results from preliminary report of the RECOVERY trial, as well as from final results [209] are related to the comparison of oral or intravenous dexamethasone 6 mg given once daily for up to ten days (2104 patients) plus the usual standard of care vs. usual care alone (4321 patients). Authors showed that overall, 482 (22.9%) patients allocated dexamethasone and 1110 (25.7%) patients allocated usual care died within 28 days (age adjusted rate ratio [RR] 0.83; 95% confidence interval [CI] 0.75 to 0.93; P<0.001). The proportional and absolute mortality rate reductions varied significantly depending on level of respiratory support at randomization (test for trend p<0.001): dexamethasone reduced deaths by one-third in patients receiving invasive mechanical ventilation (29.3% vs. 41.4%, RR 0.64 [95% CI 0.51 to 0.81]), by one-fifth in patients receiving oxygen without invasive mechanical ventilation (23.3% vs. 26.2%, RR 0.82 [95% CI 0.72 to 0.94], but did not reduce mortality in patients not receiving respiratory support at randomization (17.8% vs. 14.0%, RR 1.19 [95% CI 0.91 to 1.55]. Allocation to dexamethasone was associated with a shorter duration of hospitalization than usual care (median 12 days vs. 13 days) and a greater probability of discharge within 28 days (rate ratio 1.10 [95% CI 1.03 to 1.17]) with the greatest effect seen among those receiving invasive mechanical ventilation at baseline (11.5 by chi-square test for trend). The risk of progression to invasive mechanical ventilation was lower among those allocated dexamethasone vs. usual care (risk ratio 0.92 [95% CI 0.84 to 1.01).

Reduktion der Mortalität RR -30% bei Pts. mit künstlicher Beatmung

RR -20% bei Pts. mit Sauerstoff ohne invasive Beatmung

ohne Effekt auf Mortalität bei Pts ohne Untestützun bei Beatmung

zusätzlich: kürzere Hospitalisierung

Ongoing analyses regarding cause-specific mortality, the need for renal dialysis or hemofiltration, and the duration of ventilation [208, 210] are now finalised [209]; the incidence of death from other causes was similar in the dexamethasone group and the usual care group. Among the patients who were not receiving renal-replacement therapy (renal dialysis or hemofiltration) at randomization, the number of patients who received this treatment within 28 days was lower in the dexamethasone group than in the usual care group (risk ratio, 0.61; 95% CI, 0.48 to 0.76). Among those who were receiving invasive mechanical ventilation at randomization, successful cessation of invasive mechanical ventilation was more likely in the dexamethasone group than in the usual care group (rate ratio, 1.47; 95% CI, 1.20 to 1.78). In the subgroup of patients with available data, the incidence of new cardiac arrhythmia was similar in the dexamethasone group and the usual care group. There were four

RECOVERY Subgruppenanalysen

reports of a serious adverse reaction that was deemed by the investigators to be related to dexamethasone: two of hyperglycemia, one of gastrointestinal hemorrhage, and one of psychosis (all recognized adverse effects of glucocorticoids).

CoDEX
299 Pt (Brasilien)

kein signifikanter Unterschied, aber wegen Abbruch "underpowered" für valide Ergebnisse

The **CoDEX trial** (**NCT04327401**) randomized 299 patients in 41 ICUs in Brazil with moderate or severe ARDS and COVID-19 to open-label high-dose dexamethasone (20 mg/d for 5 days, then 10 mg/d for 5 days) vs usual care alone, with the primary outcome ventilator-free days through day 28, which were greater in patients randomized to dexamethasone (6.6 vs 4.0, p=0.04). 28-day mortality was not significantly different between patients randomized to corticosteroids vs usual care (56.3% vs 61.5%, p=0.83); stopping the study early when RECOVERY results were announced resulted in a sample size that was underpowered to adequately evaluate the effect of corticosteroids on mortality and other secondary outcomes [211, 212].

CAPE COVID
149 Pts (Frankreich)
bessere Ergebnisse mit hydrocortisone

The **CAPE COVID trial** (**NCT02517489**) was blinded, placebo-controlled trial randomized 149 patients in 9 ICUs in France with severe respiratory disease from COVID-19 to low-dose hydrocortisone (200 mg/d infusion, tapered per protocol) vs placebo. The primary outcome of 21-day treatment failure, defined as death or ongoing respiratory support with mechanical ventilation or high-flow oxygen, occurred in 42.1% of patients randomized to hydrocortisone vs 50.7% of those randomized to placebo (p=0.29) [212, 213].

REMAP-CAP
403 Pts (UK, CA, USA)
bessere Ergebnisse mit hydrocortisone

The **REMAP-CAP trial** (**NCT02735707**), an existing multicenter, multinational adaptive platform trial for pneumonia, randomized 403 patients with severe COVID-19 (in the intensive care unit and receiving respiratory or cardiovascular organ support) to 1 of 3 open-label groups: fixed low-dose hydrocortisone, shock-dependent hydrocortisone, or no hydrocortisone. The primary study outcome was days patients remained alive and free of organ support to day 21. The Bayesian model found that fixed-dose hydrocortisone (93% probability), as well as shock-dependent hydrocortisone (80% probability), were both likely superior to no hydrocortisone, but data were insufficient to confirm a single optimal regimen. In addition, the probabilities did not meet the prespecified probabilities to define success [212, 214].

MetCOVID
418 Pts (Brasilien)
methylprednisolone
kein Unterschied zwischen Gruppen bei Mortalität
methylprednisolone
Subgruppenanalyse: >60 Jahre bessere Ergebnisse

MetCOVID trial (**NCT04343729**) was parallel, double-blind, placebo-controlled, randomized, phase IIb clinical trial, performed with hospitalized patients aged ≥ 18 years with clinical, epidemiological and/or radiological suspected COVID-19, at a tertiary care facility in Brazil. 416 patients were randomly allocated (1:1 ratio) to receive either intravenous methylprednisolone (0.5 mg/kg) or placebo (saline solution), twice daily, for 5 days. Mortality at day 28 was not different between groups. A subgroup analysis showed that patients over 60 years in the methylprednisolone group had a lower mortality rate at day 28. Patients in the methylprednisolone arm tended to need more insulin therapy, and no difference was seen in virus clearance in respiratory secretion until day 7 [215].

GLUCOCOVID
85 Pts (Spanien)
Methylprednisolone

bessere Ergebnisse bei „composite"Endpunkten

Ergebnisse sind ebenfalls alters-abhängig

GLUCOCOVID trial (**EudraCT 2020-001934-37**) was multicentric, partially randomized, preference, open-label trial, including adults with COVID-19 pneumonia, impaired gas exchange and biochemical evidence of hyper-inflammation, aimed to determine whether a 6-day course of intravenous methylprednisolone improves outcome in patients with SARS CoV-2 infection at risk of developing Acute Respiratory Distress Syndrome (ARDS). Patients were assigned to standard of care (SOC), or SOC plus intravenous methylprednisolone (40mg/12h 3 days, then 20mg/12h 3 days). The use of methylprednisolone was associated with a reduced risk of the composite

endpoint in the intention-to-treat, age-stratified analysis (combined risk ratio -RR- 0.55 [95% CI 0.33-0.91]; p=0.024). In the per-protocol analysis, RR was 0.11 (0.01-0.83) in patients aged 72 yr or less, 0.61 (0.32-1.17) in those over 72 yr, and 0.37 (0.19-0.74, p=0.0037) in the whole group after age-adjustment by stratification. The decrease in C-reactive protein levels was more pronounced in the methylprednisolone group (p=0.0003). Hyperglycaemia was more frequent in the methylprednisolone group [215].

Okt 2020:
RCT (Iran)
68 Pts.

schwere Erkrankung

signifikante Ergebnisse bei klinischer Verbesserung und bei Mortalität

Edalatifard et al. 2020 [216] published results of a single-blind, randomized, controlled, clinical trial involving severe hospitalized patients with confirmed COVID-19 at the early pulmonary phase of the illness in Iran (**IRCT20200404046947N1**). Sixty-eight eligible patients underwent randomization (34 patients in each group) The percentage of improved patients was significantly higher in the methylprednisolone group than in the standard care group (32 (94.1%) vs 16 (57.1%); P =0.001) and the mortality rate was significantly lower in the methylprednisolone group (2 (5.9%) vs 12 (42.9%); P <0.001). Patients in the methylprednisolone intervention group had a significantly increased survival time compared with the patients in the standard care group [Log rank test: P<0.001; Hazard ratio: 0.293; 95% CI: 0.154-0.555]. A total of two patients in each group (5.8% and 7.1% respectively) showed severe adverse events between initiation of treatment and the end of the study. There were one infection and one edema adverse event in the methylprednisolone group and two shock adverse events in the standard care group. Following the use of high dose of corticosteroids, most of the patients required insulin due to their known or hidden diabetes, and the insulin requirement was increased in the intervention group especially in diabetic and overweight patients.

Phase 2 RCT
(Iran)
29 Pts.

signifikante Vorteile bei Mortalität

Farahani et al. 2020 [217] reported, as preprint, results from phase 2, double-blind, randomized, clinical trial in 29 adults with intermediate or severe COVID-19 with PaO2/FiO2 less than 300 and progressive disease unresponsive to standard treatments admitted to the intensive care unit (ICU) (**IRCT20200406046963N1**): The investigation group received the recommended regimen plus methylprednisolone (1000mg/day for three days) and oral prednisolone 1mg/kg with tapering of dose within ten days. There was no mortality among the patients receiving the methylprednisolone treatment, but the mortality was high in patients without methylprednisolone therapy. In addition to improvement of respiratory outcome, Glasgow Coma Scale (GCS) of methylprednisolone group significantly (p < 0.001) improved also.

3 weitere kleine Studien

Results from three unpublished studies were found related to hydrocortisone (NCT04348305), methylprednisolone (NCT04244591) and dexamethasone (NCT04325061), which included small number of COVID-19 patients (from 19 to 47), in comparisons to placebo or standard care. RCTs results, the meta-analysis results and SoF table will be updated after results are published in peer-review journals.

Metaanalyse von 7 RCTs

Reduktion von Gesamtmortalität
Verbesserung der klinischen Symptomatik

unsichere Evidenz bei anderen Endpunkten

Meta-analysis data on high, low and very low certainty of evidence, related to effectiveness and safety of dexamethasone and other corticosteroids reported in 7 RCTs, can be found in the **Summary of Findings** Table 3.17-1. In summary, according to the results of six RCTs with high certainty of evidence, corticosteroids reduce the risk of all-cause mortality D14-28 in COVID-19 patients (RR 0.90, 95% CI 0.83 to 0.97; absolute effect estimate 25 fewer per 1000 (95% CI from 23 fewer to 27 fewer). The same is true for outcome WHO progression score level 7 or above D14-28 (RR 0.88, 95% CI 0.79 to 0.98, high certainty of evidence, 4 RCTs). Corticosteroids may reduce the WHO

progression score level 6 or above D14-28 (RR 0.87, 95% CI 0.78 to 0.97, low certainty of evidence, 3 RCTs). The evidence is very uncertain about the effect of corticosteroids on outcomes: Clinical improvement D14-28 (RR 1.25, 95% CI 0.82 to 1.90, very low certainty of evidence, 2 RCTs), Adverse events (RR 1.49, 95% CI 0.11 to 20.63, very low certainty of evidence, 2 RCTs) and Serious adverse events (RR 0.88, 95% CI 0.48 to 1.60, very low certainty of evidence, 5 RCTs).

*Table 3.17-1: Summary of findings table, on **dexamethasone and other corticosteroids** (7 RCTs: Horbey, Tomazini, Dequin, REMAP-CAP Investigators, Jeronimo, Corral, Edalatifard)*

Corticosteroids compared to Standard Care/Placebo for Mild/Moderate/Severe/Critical COVID-19
Patient or population: Mild/Moderate/Severe/Critical COVID-19
Setting: Worldwide
Intervention: Corticosteroids
Comparison: Standard Care/Placebo

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care/Placebo	Risk with Corticosteroids				
Viral negative conversion D3 - not reported	-	-	-	-	-	Outcome not yet measured or reported
Viral negative conversion D7	474 per 1,000	**478 per 1,000** (360 to 635)	**RR 1.01** (0.76 to 1.34)	212 (1 RCT) [b]	⨁◯◯◯ VERY LOW [c,d,e]	
Clinical improvement D7 - not reported	-	-	-	-	-	Outcome not yet measured or reported
Clinical improvement D14-28	620 per 1,000	**775 per 1,000** (508 to 1,000)	**RR 1.25** (0.82 to 1.90)	6724 (2 RCTs) [f]	⨁◯◯◯ VERY LOW [g,h,i]	
WHO progression score level 6 or above D7 - not reported	-	-	-	-	-	Outcome not yet measured or reported
WHO progression score level 6 or above D14-28	720 per 1,000	**626 per 1,000** (562 to 698)	**RR 0.87** (0.78 to 0.97)	512 (3 RCTs) [j]	⨁⨁◯◯ LOW [k,l]	
WHO progression score level 7 or above D7 - not reported	-	-	-	-	-	Outcome not yet measured or reported
WHO progression score level 7 or above D14-28	254 per 1,000	**224 per 1,000** (201 to 249)	**RR 0.88** (0.79 to 0.98)	6937 (4 RCTs) [m]	⨁⨁⨁⨁ HIGH	
All-cause mortality D7	246 per 1,000	**187 per 1,000** (128 to 271)	**RR 0.76** (0.52 to 1.10)	416 (1 RCT) [b]	⨁⨁◯◯ LOW [d,e]	
All-cause mortality D14-28	27 per 100	**25 per 100** (23 to 27)	**RR 0.90** (0.83 to 0.97)	7591 (6 RCTs) [n]	⨁⨁⨁⨁ HIGH	
Adverse events	68 per 1,000	**101 per 1,000** (7 to 1,000)	**RR 1.49** (0.11 to 20.63)	363 (2 RCTs) [o]	⨁◯◯◯ VERY LOW [k,p,q]	
Serious adverse events	86 per 1,000	**75 per 1,000** (41 to 137)	**RR 0.88** (0.48 to 1.60)	817 (5 RCTs) [r]	⨁◯◯◯ VERY LOW [q,s]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; **RR**: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last update: November 10, 2020; b. Prado Jeronimo CM, 2020; c. Risk of bias downgraded by 1 level: high risk due to missing data; d. Indirectness downgraded by 1 level: single study from a single institution, therefore results in this population might not be generalizable to other settings; e. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect and low number of participants; f. Horby P (RECOVERY Trial), 2020; Tomazini BM, 2020; g. Risk of bias downgraded by 1 level: some concerns regarding deviations from intended intervention and outcome measurement; h. Inconsistency downgraded by 1 level: I^2=74.1%; i. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect; j. Corral-Gudino L, 2020; Dequin P-F, 2020; Tomazini BM, 2020; k. Risk of bias downgraded by 1 level: some concerns or high risk regarding adequate randomization, deviations from intended interventions and outcome measurement; l. Imprecision downgraded by 1 level: due to low number of events and/or participants; m. Corral-Gudino L, 2020; Dequin P-F, 2020; Horby P (RECOVERY Trial), 2020; Tomazini BM, 2020; n. Angus DC, 2020; Corral-Gudino L, 2020; Dequin P-F, 2020; Horby P (RECOVERY Trial), 2020; Prado Jeronimo CM, 2020; Tomazini BM, 2020; o. Corral-Gudino L, 2020; Tomazini BM, 2020; p. Inconsistency downgraded by 1 level: I^2=81.6%; q. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants; r. Angus DC, 2020; Corral-Gudino L, 2020; Edalatifard M, 2020; Dequin P-F, 2020; Tomazini BM, 2020; s. Risk of bias downgraded by 1 level: some concerns or high risk regarding adequate randomization, deviations from intended interventions, missing data and outcome measurement

3.17.1 Inhaled corticosteroids: Budesonide

About the drug under consideration

Budesonide is a type of medicine known as a steroid (also called a corticosteroid). Inhaled budesonide is a medicine used for asthma and chronic obstructive pulmonary disease (COPD).

Budesonid: Glucocorticoid zum Inhalieren bei COPD

Results of publications

On April 9th, the results of an open-label, parallel-group, phase 2, randomised controlled trial (Steroids in COVID-19; STOIC) of inhaled budesonide, compared with usual care, in adults within 7 days of the onset of mild COVID-19 symptoms was published [218]. From July 16 to Dec 9, 2020, 146 participants were randomly assigned—73 to usual care and 73 to budesonide. The number needed to treat with inhaled budesonide to reduce COVID-19 deterioration was eight. Clinical recovery was 1 day shorter in the budesonide group compared with the usual care group (median 7 days [95% CI 6 to 9] in the budesonide group vs 8 days [7 to 11] in the usual care group; log-rank test p=0·007). The mean proportion of days with a fever in the first 14 days was lower in the budesonide group (2%, SD 6) than the usual care group (8%, SD 18; Wilcoxon test p=0·051) and the proportion of participants with at least 1 day of fever was lower in the budesonide group when compared with the usual care group. As-needed antipyretic medication was required for fewer proportion of days in the budesonide group compared with the usual care group (27% [IQR 0–50] vs 50% [15–71]; p=0·025) Fewer participants randomly assigned to budesonide had persistent symptoms at days 14 and 28 compared with participants receiving usual care (difference in proportions 0·204, 95% CI 0·075 to 0·334; p=0·003). Budesonide was safe, with only five (7%) participants reporting self-limiting adverse events.

Phase 2 RCT (STOIC)
167 Pts.
milde Erkrankung

NNT 8
-1 Tag weniger lang krank

weniger andauerende Symptome unter Budesonid

On April 12th a pre-print of an interim analyses from the PRINCIPLE trial was published [219]. PRINCIPLE is a multicenter, open-label, multi-arm, adaptive platform randomized controlled trial involving people aged ≥65 years, or ≥50 years with comorbidities, and unwell ≤14 days with suspected COVID-19 in the community (PRINCIPLE). Participants were randomized to usual care, usual care plus inhaled budesonide (800μg twice daily for 14 days), or usual care plus other interventions. The trial opened on April 2, 2020. Randomization to inhaled budesonide began on November 27, 2020 and was stopped on March 31, 2021 based on an interim analysis using data from March 4, 2021. Here, we report updated interim analysis data from March 25, 2021, at which point the trial had randomized 4663 participants with suspected COVID-19. Of these, 2617 (56.1%) tested SARS-CoV-2 positive and contributed data to this interim budesonide primary analysis; 751 budesonide, 1028 usual care and 643 to other interventions. Time to first self-reported recovery was shorter in the budesonide group compared to usual care (hazard ratio 1.208 [95% BCI 1.076 – 1.356], probability of superiority 0.999, estimated benefit [95% BCI] of 3.011 [1.134 – 5.41] days). Among those in the interim budesonide primary analysis who had the opportunity to contribute data for 28 days follow up, there were 59/692 (8.5%) COVID-19 related hospitalizations/deaths in the budesonide group vs 100/968 (10.3%) in the usual care group (estimated percentage benefit, 2.1% [95% BCI −0.7% – 4.8%], probability of superiority 0.928). In this updated interim analysis, inhaled budesonide reduced time to recovery by a median of 3 days in people with COVID-19 with risk factors for adverse outcomes. Once 28 day follow up is complete for all participants randomized to budesonide, final analyses of time to recovery and hospitalization/death will be published. (Funded by the

RCT Interim Auswertung PRINCIPLE
4663 Pts.,
davon 751 mit Budesonid
frühzeitiger Abbruch

Vekürzung der Zeit der Erkrankung um ca 3 Tage

geringe Effekte auf Hospitalisierung/ Tod

National Institute of Health Research/ United Kingdom Research Innovation [MC_PC_19079]; PRINCIPLE ISRCTN number, ISRCTN86534580.)

3.18 Anakinra (Kineret®)

About the drug under consideration

Immunsuppressivum, humaner Interleukin-1 Rezeptorantagonist

EMA-Zulassung für Rheumatoide Arthritis seit 2002

Anakinra (Kineret®) is an immunosuppressive medicine, a copy of a natural human protein - 'human interleukin 1 receptor antagonist' (r-metHuIL-1ra, produced in Escherichia coli cells by recombinant DNA technology). Anakinra neutralises the biologic activity of interleukin-1α (IL-1α) and interleukin-1β (IL-1β) by competitively inhibiting their binding to interleukin-1 type I receptor (IL-1RI). Interleukin-1 (IL-1) is a pivotal pro-inflammatory cytokine mediating many cellular responses including those important in synovial inflammation. Anakinra is not authorised in Covid-19 patients (EMA, FDA).

mehrere laufende Studien, Empfehlung des US COVID-19 Treatment Guidelines Panel: insuffiziente Datenlage

The **US COVID-19 Treatment Guidelines Panel** stated that there are insufficient data to recommend either for or against Interleukin-1 inhibitors (e.g., anakinra) therapy in patients with COVID-19 disease [86].

Withdrawn, suspended or terminated studies

ANACONDA (Frankreich) 71 hospitaliserte Pts

wegen Sicherheitsbdenken abgebrochen

nun aber die Aussetzung der Studie aufgehoben

One RCT was found as suspended – ANACONDA (NCT04364009) –due to efficiency and safety reasons, after enrolment of 71 hospitalized COVID-19 patients in France. The intermediate review of data from this clinical trial showed early excess mortality in the group of patients treated with anakinra combined with standard optimized care, compared to the group of patients treated with standard optimized care alone. On October 29, 2020, the French National Agency for Medicines and Health Products Safety (ANSM) announced that inclusions in clinical trials evaluating anakinra in the treatment of COVID-19 are suspended due to safety information regarding the ANACONDA-COVID-19 clinical trial, https://ansm.sante.fr/S-informer/Actualite/Suspension-des-inclusions-en-France-dans-les-essais-clinique-evaluant-l-anakinra-dans-la-prise-en-charge-de-la-COVID-19-Point-d-information. In December 2020, ANSM lifted the suspension of trials with anakinra because after further analysis in France and the EU, the risk was not confirmed.

2 RCTs abgebrochen

Two RCTs were found as terminated: NCT04366232 (JAKINCOV), due investigator decision in France, on anakinra alone and in combination with ruxolitinib, and NCT04324021 in Italy and US because of recruitment issues.

Studiengruppe in RECOVERY

Currently, anakinra is investigated as a third option in the second randomisation for children >1 year old with hyperinflammatory syndrome associated with COVID-19 in children (PIMS-TS) in the RECOVERY (Randomised Evaluation of COVid-19 thERapY) trial, led by the University of Oxford [165].

Results of publications

1 Publikation eines RCTs

Currently, one publication related to an RCT of anakinra treatment in COVID-19 patients was found.

RCT, CORIMUNO-19

Rekrutierung nach 116 Pts. angehalten

The CORIMUNO-19 Collaborative group published results from a multicentre, open-label, Bayesian randomised clinical trial (**CORIMUNO-ANA-1, NCT04341584**), nested within the CORIMUNO-19 cohort, in France with mild-to-moderate COVID-19 pneumonia, severe acute respiratory syndrome coronavirus 2 infection confirmed by real-time RT-PCR, requiring at least 3 L/min of oxygen by mask or nasal cannula but without ventilation assistance, a score of 5 on the WHO Clinical Progression Scale (WHO-CPS), and a C-reactive protein serum concentration of more than 25 mg/L not requiring admission to the intensive care unit at admission to hospital [220]. Eligible patients were randomly assigned (1:1), stratified by centre and blocked with varying block sizes (randomly of size two or four), to either usual care plus anakinra (200 mg twice a day on days 1–3, 100 mg twice on day 4, 100 mg once on day 5) or usual care alone. The study was **stopped early,** following the recommendation of the data and safety monitoring board, after the recruitment of 116 patients: 59 were assigned to the anakinra group and 57 were assigned to the usual care group.

Wirksamkeit: keine Reduktion der Gesamtsterblichkeit oder der Pts, die früher aus Spital entlassen werden

Nebenwirkungen aber gleich

Effectiveness and safety data summary can be found in the **Summary of Findings** Table 3.18-1. Low certainty evidence from one recently published RCT (stopped early) showed that anakinra, compared to standard care, does not reduce All-cause mortality (RR 0.93, 95% CI 0.47 to 1.83; 17 fewer per 1.000, 95% CI from 125 fewer to 196 more), and doesn't increase the number of patients discharged (RR 0.93, 95% CI 0.69 to 1.26; 43 fewer per 1.000, 95% CI from 192 fewer to 161 more), as well as the number of patients with any adverse events (RR 1.18, 95% CI 0.78 to 1.76; 75 more per 1.000, 95% CI from 92 fewer to 4 318 more) and the number of patients with serious adverse events (RR 1.20, 95% CI 0.77 to 1.85; 76 more per 1.000, 95% CI from 88 fewer to 325 more) [221].

*Table 3.18-1: Summary of findings table, on **anakinra** (1 RCTs: CORIMUNO-19 Collaborative group)*

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Number of participants (studies)	Certainty of evidence	Comments
	Risk with Standard treatment	Risk with Anakinra				
All-cause mortality at 28 days	236 per 1000	219 per 1000	**RR 0.93** (0.47 to 1.83)	114 (1 RCT) [a]	⊕⊕◯◯ LOW	**Absolute effect (95% CI)** **17 fewer per 1.000** (from 125 fewer to 196 more)
Number of patients discharged	618 per 1000	575 per 1000	**RR 0.93** (0.69 to 1.26)	114 (1 RCT) [a]	⊕⊕◯◯ LOW	**Absolute effect (95% CI)** **43 fewer per 1.000** (from 192 fewer to 161 more)
Number of patients with any adverse event	418 per 1000	493 per 1000	**RR 1.18** (0.78 to 1.76)	114 (1 RCT) [a]	⊕⊕◯◯ LOW	**Absolute effect (95% CI)** **75 more per 1.000** (from 92 fewer to 318 more)
Number of patients with serious adverse events	382 per 100	458 per 1000	**RR 1.20** (0.77 to 1.85)	114 (1 RCT) [a]	⊕⊕◯◯ LOW	**76 more per 1.000** (from 88 fewer to 325 more)

Source: ref Cruciani F, De Crescenzo F, Vecchi S, Saulle R, Mitrova Z, Amato L, Davoli M. GRADE Table. Should Anakinra (Interleukin-1 receptor antagonist) compared to Standard treatment be used for COVID-19 patients? 2021. https://www.deplazio.net/farmacicovid/tabelle-grade.html; https://www.deplazio.net/farmacicovid/files/tabelle-grade/Anakinra-compared-to-Standard-treatment-for-COVID-19-patients.pdf

[a] ref CORIMUNO-19 Collaborative group. Effect of anakinra versus usual care in adults in hospital with COVID-19 and mild-to-moderate pneumonia (CORIMUNO-ANA-1): a randomised controlled trial. Lancet Respir Med. 2021(S2213-2600(20)30556-7).

Abbreviations: CI=Confidence interval; RR=Risk ratio

Explanations: **Low certainty of evidence:** Downgraded of one level for high risk of performance bias and unclear risk of selection bias; Downgraded of one level for small sample size (<200)

3.19 Colchicine

About the drug under consideration

Colchicine is an alkaloid isolated from the autumn crocus, Colchicinum autumnale, with anti-gout and anti-inflammatory activities. Colchicine is available throughout the world in a generic form [222].

toxisches Alkaloid wirkt als Zellgift (Mitosehemmung)

Colchicine is not authorised in Covid-19 patients (EMA, FDA).

generisch

Withdrawn, suspended or terminated studies

One RCT was found as withdrawn because no funding is available (NCT04603690; no suspended or terminated interventional studies were found on colchicine in ClinicalTrials.gov and EUdraCT registers.

1 RCT zurückgezogen

Results of publications

Deftereos et al. 2020 [223] reported results from open-label, randomized controled trial (**NCT04326790**) on 105 patients **hospitalized** with COVID-19 in 16 tertiary hospitals in Greece (randomization in a 1:1 allocation to either standard medical treatment or colchicine with standard medical treatment). Patient recruitment was terminated on April 27, 2020, because of slow enrollment as a result of the rapid flattening of the curve of COVID-19 cases in Greece. The clinical primary end point rate was 14.0% in the control group (7 of 50 patients) and 1.8% in the colchicine group (1 of 55 patients) (odds ratio, 0.11; 95% CI, 0.01-0.96; p=0.02). Mean (SD) event-free survival time was 18.6 (0.83) days the in the control group vs 20.7 (0.31) in the colchicine group (log rank p=0.03). Adverse events were similar in the 2 groups, except for diarrhea, which was more frequent with colchicine group than the control group (25 patients [45.5%] vs 9 patients [18.0%]; p=0.003).

1 publizierter RCT (Griechenland): 105 Pts.

klinisch gering-relevanter Unterschied bei Verbesserung der Erkrankung

viele Surrogatendpunkte niedrige Evidenz

Salehzadeh et al. 2020 [224] reported results (as preprint) from prospective, open-label, randomized and double blind clinical trial, in 100 patients **hospitalized** with COVID-19 in Iran (**IRCT20200418047126N1**). Patients were randomized in a 1:1 allocation, to either standard medical treatment (hydroxychloroquine) or colchicine with standard medical treatment. Colchicine group were received 1 mg tablet of colchicine daily alongside the hydroxychloroquine for 6 days. Duration of hospitalisation and duration of fever were significantly different between patients groups, in favour of colchicine (p<0.05). Although in colchicine group dyspnea was improved more rapid than the placebo group, difference was not statistically significant. None of the patients died or were readmitted.

RCT preprint (Iran) 100 Pts.

kein Unterschied

Lopes et al. 2020 [225], reported (as preprint) interim results of a single-center, randomized, double-blinded, placebo controlled clinical trial of colchicine for the treatment of 38 **moderate to severe COVID-19** patients in Brazil. Thirty-five patients (18 for placebo and 17 for colchicine) completed the study. Median (and interquartile range) time of need for supplemental oxygen was 3.0 (1.5- 6.5) days for the colchicine group and 7.0 (3.0-8.5) days for placebo group (p=0.02). Median (IQR) time of hospitalization was 6.0 (4.0-8.5) days for the colchicine group and 8.5 (5.5-11.0) days for placebo group (p=0.03). At day 2, 53% vs 83% of patients maintained the need for supplemental oxygen, while at day 7 the values were 6% vs 39%, in the colchicine and placebo groups, respectively (log rank; p=0.01). Hospitalization was maintained for 53% vs 78% of patients at day 5 and 6%

RCT preprint (Brasilien) 38 Pt.

Reduktion von Sauerstoff Supplementierung und von Hospitalisierung

vs 17% at day 10, for the colchicine and placebo groups, respectively (log rank; p=0.01). One patient per group needed admission to ICU. No recruited patient died. At day 4, patients of colchicine group presented significant reduction of serum C-reactive protein compared to baseline (p<0.001). The majority of adverse events were mild and did not lead to patient withdrawal. Diarrhea was more frequent in the colchicine group (p=0.17). Cardiac adverse events were absent.

RCT
4.159 Patient*innen
nicht-hospitalisiert

Tod oder Hospitalisierung in
4,6% vs. 6% zugunsten von Colchicine

Tardif et al. 2021 [226] published as preprint results from randomized, double-blind trial involving **non-hospitalised** patients with COVID-19 diagnosed by polymerase chain reaction (PCR) testing or clinical criteria (COLCORONA, NCT04322682). The patients were randomly assigned to receive colchicine (0.5 mg twice daily for 3 days and once daily thereafter) or placebo for 30 days. The primary efficacy endpoint was the composite of death or hospitalization for COVID-19 [226]. Among the 4159 patients with PCR-confirmed COVID-19, the primary endpoint occurred in 4.6% and 6.0% of patients in the colchicine and placebo groups, respectively (odds ratio, 0.75; 95% CI, 0.57 to 0.99; p=0.04). The odds ratios were 0.75 (95% CI, 0.57 to 0.99) for hospitalization due to COVID-19, 0.50 (95% CI, 0.23 to 1.07) for mechanical ventilation, and 0.56 (95% CI, 0.19 to 1.66) for death. Serious adverse events were reported in 4.9% and 6.3% in the colchicine and placebo groups (p=0.05); pneumonia occurred in 2.9% and 4.1% of patients (p=0.02). Diarrhea was reported in 13.7% and 7.3% in the colchicine and placebo groups (p<0.0001).

Zusammenfassung von 4 RCTs
sehr unsichere Evidenz

Summary of Finding table related to colchicine compared to standard care for moderate/severe COVID-19 patients, related to 4 RCTs mentioned above, is presented in Table 3.19-1 below. According to currently available evidence, the evidence is very uncertain about the effect of colchicine on outcomes: All-cause mortality D28 (RR 0.47, 95% CI 0.18 to 1.25, 4 RCTs, very low certainty of evidence) and Clinical improvement D28 (RR not estimable, 1 RCTs, very low certainty of evidence). Colchicine may not effect WHO progression score level 7 or above D28 (RR 0.16, 95% CI 0.02 to 1.29, 2 RCTs, low certainty of evidence) and Serious adverse events (RR 0.79, 95% CI 0.62 to 1.00, 3 RCTs, low certainty of evidence). Colchicine probably increase Adverse events (RR 1.55, 95% CI 1.37 to 1.75, 2 RCTs, moderate certainty of evidence).

RECOVERY beendet Rekrutierung wegen Zweifel an Wirksamkeit

kein Unterschied zu SoC

On March 5, 2021 **RECOVERY trial chief investigators** announced that **recruitment to the colchicine arm** of the RECOVERY trial has now **closed**. The independent Data Monitoring Committee (DMC) saw **no convincing evidence that further recruitment would provide conclusive proof of worthwhile mortality benefit either overall or in any pre-specified subgroup**. The DMC reviewed data on patients randomised to colchicine vs. usual care alone. The preliminary analysisis based on 2178 reported deaths among 11,162 randomised patients, 94% of whom were being treated with a corticosteroid such as dexamethasone. There is no significant difference in the primary endpoint of 28-day mortality (20% colchicine vs. 19% usual care alone; risk ratio 1.02 [95% confidence interval 0.94-1.11]; p=0.63). Follow-up of patients is ongoing and final results will be published as soon as possible, https://www.recoverytrial.net/news/recovery-trial-closes-recruitment-to-colchicine-treatment-for-patients-hospitalised-with-covid-19

*Table 3.19-1: Summary of findings table on **colchicine compared to standard care** (4 RCT: Deftereos, Lopes, Salehzadeh, Tardif) - https://covid-nma.com/living_data/index.php)*

Colchicine compared to Standard care or Placebo for Moderate/Severe/Critical COVID-19

Patient or population: Moderate/Severe/Critical COVID-19
Setting: Worldwide
Intervention: Colchicine
Comparison: Standard care or Placebo

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard care or Placebo	Risk with Colchicine				
Viral negative conversion D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement D28	1,000 per 1,000	**0 per 1,000** (0 to 0)	not estimable	38 (1 RCT) [b]	⨁◯◯◯ VERY LOW [c,d]	all participants in both groups had the event
Clinical improvement D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above) D28	82 per 1,000	**13 per 1,000** (2 to 106)	**RR 0.16** (0.02 to 1.29)	148 (2 RCTs) [e]	⨁⨁◯◯ LOW [f]	
WHO progression score (level 7 or above) D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D28	5 per 1,000	**3 per 1,000** (1 to 7)	**RR 0.47** (0.18 to 1.25)	4746 (4 RCTs) [g]	⨁◯◯◯ VERY LOW [h,i]	
All-cause mortality D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
Adverse events	155 per 1,000	**240 per 1,000** (212 to 271)	**RR 1.55** (1.37 to 1.75)	4526 (2 RCTs) [j]	⨁⨁⨁◯ MODERATE [k]	
Serious adverse events	61 per 1,000	**48 per 1,000** (38 to 61)	**RR 0.79** (0.62 to 1.00)	4636 (3 RCTs) [l]	⨁⨁◯◯ LOW [k,m]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: Confidence interval; **RR**: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty**: We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty**: Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty**: We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

a. Last update: March 4, 2021; b. Lopes MIF, 2020; c. Indirectness downgraded by 1 level: single study from a single country, therefore results in this population might not be generalizable to other settings; d. Imprecision downgraded by 2 levels: very small sample size where all participants had the event, no relative effect calculated; e. Deftereos S, 2020; Lopes MIF, 2020; f. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants; g. Tardif JC, 2021; Deftereos S, 2020; Lopes MIF, 2020; Salehzadeh F, 2020; h. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviation from intended interventions and selection of reported results; i. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm; j. Lopes MIF, 2020; Tardif JC, 2021; k. Risk of bias downgraded by 1 level: some concerns or high risk regarding adequate randomization, missing data and selection of reported results; l. Tardif JC, 2021; Deftereos S, 2020; Lopes MIF, 2020; m. Imprecision downgraded by 1 level: due to wide confidence interval consistent with the possibility for benefit and the possibility for no effect

3.20 Nafamostat (Futhan©)

About the drug under consideration

Nafamostat mesilate (FUT-175, Futhan®, Nichi-Iko Pharmaceutical) is (with implications on coagulation, fibrinolysis, complement system, inflammatory cytokine release) and is quickly hydrolysed, the reason why it is typically administered as an intravenous drip. Nafamostat is not approved for any use by EMA or FDA.

Futhan®

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated interventional studies were found on nafamostat in ClinicalTrials.gov and EUdraCT registers.

keine abgeschlossenen, abgebrochenen Studien

Results of publications

keine veröffentlichten Studien

Until now, no scientific publication on randomized clinical trials of nafamostat in Covid-19 patients could be identified.

3.21 Gimsilumab

About the drug under consideration

Gimsilumab is a fully human monoclonal antibody that acts on granulocyte-macrophage colony-stimulating factor (GM-CSF) [1]; it is manufactured by Roivant Sciences Ltd. /Altasciences. Gimsilumab – ATC-code not assigned yet. Gimsilumab belongs to anti-inflammatories, antirheumatics, monoclonal antibodies drug class and has no approvement for any indication by EMA or FDA yet.

monoklonaler Antkörper in Entwicklung

EMA/ FDA: keine Zulassung

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated interventional studies were found on gimsilumab in ClinicalTrials.gov and EUdraCT registers.

keine abgeschlossenen, abgebrochenen Studien

Results of publications

keine veröffentlichten Studien

There are no published results from RCTs related to effectiveness and safety of gimsilumab for Covid-19 treatment; one Phase II study of gimsilumab is ongoing, estimated study completion date is March 2021 [227, 228].

1 Phase 2 Studie läuft

3.22 Canakinumab

About the drug under consideration

monoklonaler Antkörper
EMA Orphan Drug
Zulassung für diverse Indikationen

Canakinumab is a human monoclonal anti-human interleukin-1 beta (IL-1 beta) antibody of the IgG1/κ isotype manufactured by Novartis Pharma AG. Canakinumab binds with high affinity specifically to human IL-1 beta and neutralises the biological activity of human IL-1 beta by blocking its interaction with IL-1 receptors, thereby preventing IL-1 beta-induced gene activation and the production of inflammatory mediators [229].
Canakinumab is not authorised in Covid-19 patients (EMA, FDA).

Withdrawn, suspended or terminated studies

keine abgeschlossenen, abgebrochenen Studien

No withdrawn, suspended or terminated interventional studies were found on canakinumab in ClinicalTrials.gov and EUdraCT registers.

Results of publications

keine veröffentlichten Studien
1 Phase 3 Studie läuft

There are no published RCTs related to effectiveness and safety of canakinumab for Covid-19. Two studies of canakinumab are still ongoing: one Phase III study, estimated study completion date on December 2020 and one Phase II study, estimated completion date on December 2020 [230-232].

CAN-COVID
negative Ergebnisse
kein Unterschied

Manufacturer recently **announced preliminary interim results** from the CAN-COVID trial: the CAN-COVID trial failed to meet its primary endpoint showing that treatment with canakinumab plus standard of care (SoC) did not demonstrate a significantly greater chance of survival for patients without the need for invasive mechanical ventilation, compared with placebo plus SoC up to Day 29. The trial did not meet its key secondary endpoint of reducing the COVID-19-related death rate during the 4-week period after treatment. The safety profiles of canakinumab plus SoC and placebo plus SoC were comparable (https://www.novartis.com/coronavirus/can-covid-clinical-trial).

3.23 Lenzilumab

About the drug under consideration

monoklonaler Antikörper

für keine Indikation bislang zugelassen

FDA: für Einzelanwendungen im Notfall – compassionate use zur Verhinderung von akutem Lungenversagen

Lenzilumab is a first-in-class Humaneered® recombinant monoclonal antibody targeting human GM-CSF, with potential immunomodulatory activity, high binding affinity in the picomolar range, 94% homology to human germline, and has low immunogenicity. Following intravenous administration, lenzilumab binds to and neutralizes GM-CSF, preventing GM-CSF binding to its receptor, thereby preventing GM-CSF-mediated signaling to myeloid progenitor cells. The inhibition of GM-CSF signaling may be beneficial in improving the hyperinflammation-related lung damage in the most severe cases of COVID-19. This blockade can be achieved through antagonism of the GM-CSF receptor or the direct binding of circulating GM-CSF [233, 234].

Lenzilumab is not authorised in Covid-19 patients (EMA, FDA). FDA has approved the administration of lenzilumab for COVID-19 patients under

individual patient emergency IND applications to patients under the company's compassionate use program.

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated interventional studies were found on lenzilumab in ClinicalTrials.gov and EUdraCT registers.

Okt 2020: keine weiteren Studien

Results of publications

There are no published RCTs related to effectiveness and safety of lenzilumab for Covid-19.

A multicenter, **phase 3**, randomized, double-blinded, controlled, clinical trial with lenzilumab for the prevention of ARDS and/or death in hospitalized patients with pneumonia associated with coronavirus 2 (SARS-CoV-2) infection in COVID-19 patients is ongoing in US (NCT04351152). The primary objective of this study is to assess whether the use of lenzilumab in addition to current standard of care can alleviate the immune-mediated cytokine release syndrome (CRS) and reduce the time to recovery in 300 hospitalized patients with severe or critical COVID-19 pneumonia, with estimated completion date on September 2020 [74].

Phase 3 RCT an hospitalisierten Pts mit Lungenentzündung 300 Pts.

On March 29 2021, Humanigen announced that this phase 3 trial mentioned above has met its primary endpoint: hospitalized patients who received lenzilumab (and other treatments including steroids and/or remdesivir) have significant improvement in ventilator-free survival through day 28 following treatment—to 84.4% from 77.9% among placebo patients. As a result, the percentage of lenzilumab patients who died or needed IMV was 15.6% compared with 22.1% of placebo patients, a 54% improvement in the relative likelihood of survival without the need for IMV. Humanigen plans to use the data to seek emergency use authorisation from the FDA, https://www.businesswire.com/news/home/20210329005301/en/Humanigen-Reports-Positive-Phase-3-Topline-Results-Demonstrating-That-Lenzilumab%E2%84%A2-Improves-Survival-Without-Need-for-Mechanical-Ventilation-in-Hospitalized-Patients-With-COVID-19

3.24 Vitamin D

About the drug under consideration

Vitamin D (ergocalciferol-D2, cholecalciferol-D3) is a fat-soluble vitamin increases the intestinal absorption of calcium and phosphate. Vitamin D is absorbed from the intestine and transported by protein binding in the blood to the liver (first hydroxylation to 25-hydroxycholecalciferol) and to the kidney (2nd hydroxylation to 1,25- dihydroxycholecalciferol, active metabolite responsible for increasing calcium absorption). It has been claimed as potentially protective against the infection since it may be associated with immunocompetence, inflammation, aging, and those diseases involved in determining the outcomes of COVID-19 [235]. VIOLET RCT (NCT03096314) of early high-dose enteral vitamin D3 supplementation in critically ill, vitamin D–deficient patients who were at high risk for death did not provide an advantage over placebo with respect

protektive Wirkung gegen Infekte bekannt

assoziiert mit guter Immunantwort

VIOLET
RCT zu hoch-dosiertem Vit D3 zur Supplementierung kein Vorteil
mehrere klinische Studien laufend

to 90-day mortality or other, nonfatal outcomes among critically ill, vitamin D–deficient patients [236]. RCTs to assess efficacy and safety of vitamin D in COVID-19 patients are underway.

Vitamin D is not authorised in Covid-19 patients (EMA, FDA).

The **US COVID-19 Treatment Guidelines Panel** stated that there are **insufficient data** to recommend either **for or against** the use of vitamin D for the prevention or treatment of COVID-19 [151].

US COVID-19 Treatment Guidelines Panel: insuffiziente Datenlage

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated interventional studies were found on Vitamin D in ClinicalTrials.gov and EUdraCT registers.

Results of publications

Entrenas Castillo et al. 2020 [237] published results from parallel pilot randomized open label, double-masked clinical trial on 76 consecutive patients hospitalized with COVID-19 infection in Spain (NCT04366908). Eligible patients were allocated at a 2 calcifediol:1 no calcifediol ratio, through electronic randomization on the day of admission to take oral calcifediol (0.532 mg), or not. Patients in the calcifediol treatment group continued with oral calcifediol (0.266 mg) on day 3 and 7, and then weekly until discharge or ICU admission. Of 50 patients treated with calcifediol, one required admission to the ICU (2%), while of 26 untreated patients, 13 required admission (50 %), $p < 0.001$. Calcifediol or 25-hydroxyvitamin D, a main metabolite of vitamin D, significantly reduced the need for ICU treatment of patients requiring hospitalization due to proven COVID-19: Univariate Risk Estimate Odds Ratio for ICU in patients with Calcifediol treatment versus without Calcifediol treatment: 0.02 (95 %CI 0.002- 0.17). Multivariate Risk Estimate Odds Ratio for ICU in patients with Calcifediol treatment vs Without Calcifediol treatment ICU (adjusting by Hypertension and T2DM): 0.03 (95 %CI: 0.003-0.25). Of the patients treated with calcifediol, none died, and all were discharged, without complications. The 13 patients not treated with calcifediol, who were not admitted to the ICU, were discharged. Of the 13 patients admitted to the ICU, two died and the remaining 11 were discharged.

RCT
76 hospitalisierte Pts

Vorteil bei Verhinderung von ICU Verschlechterung der Erkrankung

Rastogi et al. 2020 [238] published results from randomized, placebo-controlled trial (NCT04459247, SHADE) on 40 COVID-19 adult asymptomatic or mildly symptomatic SARS-CoV-2 RNA positive vitamin D deficient individuals (intervention (n=16) or control (n=24) group), with outcomes measure: Proportion of patients with SARSCoV-2 RNA negative before day-21 and change in inflammatory markers. 10 (62.5%) participants in the intervention group and 5 (20.8%) participants in the control arm ($p<0.018$) became SARS-CoV-2 RNA negative. Fibrinogen levels significantly decreased with cholecalciferol supplementation (intergroup difference 0.70 ng/ml; $p=0.007$) unlike other inflammatory biomarkers.

RCT
40 Patient*innen asymptomatisch oder mild symptomatisch

Reduktion Entzündungsmarker Fibrinogen

Murai et al. 2020 [239] presented as pre-print results from double-blind, randomised, placebo-controlled trial involving 240 hospitalised patients with severe COVID-19, in Brasil (NCT04449718). A single dose of 200,000 IU of vitamin D3 supplementation was safe and effective in increasing 25-hydroxyvitamin D levels, but did not significantly reduce hospital length of stay (hazard ratio, 1.12) or any other 10 clinically-relevant outcomes compared with placebo.

RCT
240 hospitalisierte Patient*innen
kein Unterschied bei Dauer des Krankenhausaufenthalts

Summary of Finding table related to **Vitamin D compared to Standard care/Placebo** for mild/moderate/severe COVID-19 patients, related to 3 RCTs mentioned above, is presented in Table 3.24-1 below. The evidence is very uncertain about the effect of Vitamin D on outcomes: All-cause mortality D14-D28 (RR 0.56, 95% CI 0.05 to 5.85, 2 RCTs, very low certainty of evidence) and WHO progression score (level 7 or above) D14-D28 (RR 0.04, 95% CI 0.01 to 0.29, 1 RCT, very low certainty of evidence). Vitamin D may not increase Adverse events (RR 2.98, 95% CI 0.12 to 72.30, 1 RCT, low certainty of evidence).

SoF von 3 RCTs
sehr unsichere Evidenz
ev. Verhinderung von Verschlechterung

*Table 3.24-1: Summary of findings table on **Vitamin D compared to standard care** (3 RCT:Entrenas Castillo, Rastogi, Murai) - https://covid-nma.com/living_data/index.php)*

Vitamin D compared to Standard care/Placebo for Mild/Moderate/Severe COVID-19

Patient or population: Mild/Moderate/Severe COVID-19
Setting: Worldwide
Intervention: Vitamin D
Comparison: Standard care/Placebo

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard care/Placebo	Risk with Vitamin D				
Viral negative conversion D3 - not reported	-	-	-	-	-	outcome not yet measured or reported
Viral negative conversion D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
Clinical improvement D14-D28 - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO Progression Score (level 6 or above) D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO Progression Score (level 6 or above) D14-D28 - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above) D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO progression score (level 7 or above) D14-D28	500 per 1,000	**20 per 1,000** (5 to 145)	**RR 0.04** (0.01 to 0.29)	76 (1 RCT) [b]	⨁◯◯◯ VERY LOW [c,d,e]	
All-cause mortality D7 - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D14-D28	56 per 1,000	**31 per 1,000** (3 to 325)	**RR 0.56** (0.05 to 5.85)	313 (2 RCTs) [f]	⨁◯◯◯ VERY LOW [c,g,h]	
Adverse events	0 per 1,000	**0 per 1,000** (0 to 0)	**RR 2.98** (0.12 to 72.30)	237 (1 RCT) [i]	⨁⨁◯◯ LOW [h,j]	
Serious adverse events - not reported	-	-	-	-	-	outcome not yet measured or reported

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; RR: Risk ratio

GRADE Working Group grades of evidence: High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last updated: 06 December, 2020; b. Entrenas Castillo M, J Steroid Biochem Mo, 2020; c. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization and deviations from intended interventions.; d. Indirectness downgraded by 1 level: results are from a single study from a single institution, therefore results in this population might not be generalizable to other settings.; e. Imprecision downgraded by 1 level: due to low number of events and participants.; f. Entrenas Castillo M, J Steroid Biochem Mo, 2020; Murai I, medRxiv, 2020; g. Inconsistency downgraded by 1 level: I^2=58.9%; h. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of events and participants.; i. Murai I, medRxiv, 2020; j. We presume that the adverse event rates and the corresponding relative risks, are similar across diverse settings; therefore not downgraded for indirectness.

3.25 Baricitinib

About the drug under consideration

Januskinase-Inhibitor

Baricitinib is a selective and reversible inhibitor of Janus kinase (JAK)1 and JAK2. Janus kinases (JAKs) are enzymes that transduce intracellular signals from cell surface receptors for a number of cytokines and growth factors involved in haematopoiesis, inflammation and immune function. Baricitinib (Olumiant) is indicated in EU for the treatment of moderate to severe active rheumatoid arthritis in adult patients who have responded inadequately to, or who are intolerant to one or more disease-modifying anti-rheumatic drugs and for the treatment of moderate to severe atopic dermatitis in adult patients who are candidates for systemic therapy [240, 241].

Baricitinib (Olumiant) in EU für moderate bis schwere rheumatoide Arthritis zugelassen

Baricitinib (Olumiant) has not been approved by the European Medicines Agency (EMA). On November 19, 2020, the U.S. Food and Drug Administration (**FDA**) issued an **Emergency Use Authorization** (**EUA**) for the distribution and emergency use of baricitinib to be used **in combination with remdesivir** in **hospitalised adult and pediatric patients two years of age or older** with suspected or laboratory confirmed COVID-19 **who require supplemental oxygen, invasive mechanical ventilation, or extracorporeal membrane oxygenation** (ECMO) [242].

EMA: keine Zulassung für covid-19

FDA Zulassung (EUA) als Kombinations-therapie mit Remdesivir hospitalisierte Patient*innen mit Bedarf zur Beatmung

The **US COVID-19 Treatment Guidelines Panel** stated that there are **insufficient data** to recommend either **for or against** baricitinib in combination with remdesivir therapy in hospitalised patients with COVID-19 disease, in cases where corticosteroids can be used instead [151].

In the rare circumstances where corticosteroids cannot be used, the Panel recommends using baricitinib in combination with remdesivir for the treatment of COVID-19 in hospitalized, nonintubated patients who require oxygen supplementation **(BIIa).**

US COVID-19 Treatment Guidelines Panel: insuffiziente Datenlage als Kombinationstherapie + Remdesivir in hospitalisierten Pts.

The Panel **recommends against** the use of baricitinib in the absence of remdesivir, except in a clinical trial **(AIII).**

There are insufficient data for the Panel to recommend either for or against the use of baricitinib in combination with corticosteroids for the treatment of COVID-19. Since both agents are potent immunosuppressants, there is potential for an additive risk of infection.

More data are needed to clarify the role of baricitinib in the management of COVID-19. Health care providers are encouraged to discuss participation in baricitinib clinical trials with their patients [151].

Withdrawn, suspended or terminated studies

keine Studien abgebrochen, zurückgezogen

No withdrawn, suspended or terminated interventional studies were found on baricitinib in ClinicalTrials.gov and EUdraCT registers. There are several ongoing RCTs, evaluating baricitinib alone (7 RCTs and one nRCT) or in combination with other pharmaceuticals (5 RCTs), in Covid-19 hospitalised patients. One is the RECOVERY (Randomised Evaluation of COVid-19 thERapY) trial, led by the University of Oxford [165].

Results of publications

On December 11, 2020, **Kalil et al.** [243] published results from the Adaptive COVID-19 Treatment Trial (**ACTT-2**) (**NCT04401579**), multicentre, double-blind, randomised, placebo-controlled trial evaluating **baricitinib plus remdesivir with remdesivir alone** in **hospitalised adults** with Covid-19 in eight countries. Effectiveness and safety data summary can be found in the **Summary of Findings** Table 3.25-1. High certainty evidence from one published RCT, ACTT-2 trial, showed that baricitinib in combination with remdesivir does not reduce All-cause mortality, but reduces the number of patients with any adverse events as well as the number of patients with serious adverse events. Combination of baricitinib and remdesivir significantly reduced median time to recovery in hospitalised COVID-19 patients from eight days to seven days, compared to remdesivir treatment alone. Patients who required high-flow oxygen or non-invasive ventilation during hospitalisation appeared to have had the largest benefit: their median time to recovery was shortened from eighteen days to ten days. Participants' conditions at day 15 was significantly improved when they received the two therapeutics combined. The incidence of progression to death or non-invasive or invasive ventilation was statistically significant lower in the combination of baricitinib and remdesivir vs remdesivir alone, as was the incidence of progression to death or invasive ventilation [244].

RCT, ACTT-2
hospitalisierte Pts
Kombinationstherapie + Remdesivir

keine Reduktion der Gesamtmortalität
aber Reduktion der Zeit zur Erholung um 1 Tag

Pts. mit nicht-invasiver Beatmung: größter Nutzen

Reduktion der Zeit zur Erholung um 8 Tage (statt 18, nur 10 Tage)

*Table 3.25-1: Summary of findings table, on **baricitinib + remdesivir** (1 RCT: Kalil 2020)*

Question: Should Baricitinib-Remdesivir compared to Standard treatment (placebo/remdesivir) be used for COVID-19 patients?
Setting: Inpatient

Outcome	Anticipated absolute effects (95% CI)		Relative effect (95% CI)	Absolute effect (95% CI)	Number of participants (studies)	Certainty of evidence	Comments
	Risk with placebo+remdesivir	Risk with baricitinib+remdesivir					
All-cause mortality	71 per 1000	46 per 1000	**RR 0.65** (0.40 to 1.07)	**25 fewer per 1.000** (from 43 fewer to 5 more)	1033 (1 RCT) [a]	⊕⊕⊕⊕ HIGH	Baricitinib in combination with remdesivir does not reduce All-cause mortality
Number of patients with any adverse event	432 per 1000	367 per 1000	**RR 0.85** (0.73 to 0.99)	**65 fewer per 1.000** (from 117 fewer to 4 fewer)	1016 (1 RCT)[a]	⊕⊕⊕⊕ HIGH	Baricitinib in combination with remdesivir reduces the risk of AE
Number of patients with serious adverse events	210 per 1000	159 per 1000	**RR 0.76** (0.59 to 0.99)	**50 fewer per 1.000** (from 86 fewer to 2 fewer)	1013 (1 RCT)[a]	⊕⊕⊕⊕ HIGH	Baricitinib in combination with remdesivir reduces the risk of serious AE

Source: ref Cruciani F., De Crescenzo F., Vecchi S., Saulle R., Mitrova Z., Amato L., et al. Should Baricitinib-Remdesivir compared to Standard treatment (placebo/remdesivir) be used for COVID-19 patients?. 2020.

[a] ref Kalil AC, Patterson TF, Mehta AK, Tomashek KM, Wolfe CR, Ghazaryan V, et al. Baricitinib plus Remdesivir for Hospitalized Adults with Covid-19. New England Journal of Medicine. 2020. 10.1056/NEJMoa2031994.

***Abbreviations**: RR=Risk ratio; CI=Confidence interval; AE=Adverse event; SAE=Serious adverse event*

3.26 Molnupiravir

About the drug under consideration

antivirales Medikament ähnlich Remdesivir aber orale Verabreichung

Molnupiravir is the orally available pro-drug of the nucleoside analogue N4-hydroxycytidine (NHC), which has shown potent anti-influenza virus activity in mice, guinea pigs, ferrets and human airway epithelium organoids. Animal study in ferrets showed that therapeutic treatment of infected animals with molnupiravir (MK-4482/EIDD-2801) twice a day significantly reduced the SARS-CoV-2 load in the upper respiratory tract and completely suppressed spread to untreated contact animals [245, 246].

frühere Verabreichung zu Hause daher möglich

hospitalisierte, aber auch milde und moderate Erkrankung

Molnupiravir attacks the same viral enzyme as Gilead's Remdesivir, but it can be taken orally. This would allow an administration at home and, therefore, earlier in the course of the disease. According to Ridgeback Biotherapeutics, molnupiravir has an extremely high barrier to resistance. According to Merck Sharp & Dohme/ MSD, molnupiravir is aimed at the treatment of Covid-19 in patients hospitalised due to mild, moderate or severe disease, and non-hospitalized patients with mild or moderate disease [246].

weder von EMA noch FDA zugelassen

Molnupiravir is not approved by the European Medicines Agency (EMA) or the American Food and Drug Administration (FDA) [246].

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated interventional studies were found on molnupiravir in ClinicalTrials.gov and EUdraCT registers.

Results of publications

keine RCTs derzeit in Phase 1/ 2, 2 und 1/ 3 Studien mit verschiedenen Pts. Populationen

There are no published RCTs related to effectiveness and safety of molnupiravir for Covid-19. It is currently investigated in phase 1/2, 2 and 2/3 clinical trials (NCT04405570, NCT04405739, NCT04575584, NCT04575597, ISRCTN27106947), in hospitalised and non-hospitalised aduls with COVID-19.

Presseaussendung von Merck & Ridgeback 2a RCT positive Ergebnisse

On March 6, 2021 Merck and Ridgeback Biotherapeutics, LP **announced preliminary results** from Ridgeback's **phase 2a** randomized, double-blind, placebo-controlled trial to evaluate the safety, tolerability, and efficacy to eliminate SARS-CoV-2 viral RNA of molnupiravir (EIDD-2801/MK-4482), on one secondary objective, showing a reduction in time (days) to negativity of infectious virus isolation in nasopharyngeal swabs from participants with symptomatic SARS-CoV-2 infection, as determined by isolation in Vero cell line culture. At day 5, there was a reduction (nominal p=0.001, not controlled for multiplicity) in positive viral culture in subjects who received molnupiravir (all doses) compared to placebo: 0% (0/47) for molnupiravir and 24% (6/25) for placebo. Of 202 treated participants, no safety signals have been identified and of the 4 serious adverse events reported, none were considered to be study drug related, https://www.businesswire.com/news/home/20210305005610/en/.

3.27 Ivermectin

About the drug under consideration

Ivermectin (manufactured by Merck Sharp & Dohme as Mectizan and Stromectol tablets a 3 mg) is a semisynthetic, anthelmintic agent for oral administration. Ivermectin is derived from the avermectins, a class of highly active broad-spectrum, anti-parasitic agents isolated from the fermentation products of Streptomyces avermitilis. It is indicated for the treatment of the following infections: Strongyloidiasis of the intestinal tract and the treatment of onchocerciasis due to the nematode parasite Onchocerca volvulus, https://www.merck.com/product/usa/pi_circulars/s/stromectol/stromectol_pi.pdf. On the WHO's Model List of Essential Medicines it is retained in the form of a 3 mg tablet. For parasitic infections in adults, ivermectin is commonly administered as a single 12 mg oral dose (0.2mg/kg).

zugelassen als Mectizan und Stromectol gegen parasitäre Infektionen

(z.B. Onchozerkose)

Recently, Caly et al. 2020 [247] reported that ivermectin in vitro is an inhibitor of the causative virus (SARS-CoV-2), with a single addition to Vero-hSLAM cells 2 h post infection with SARS-CoV-2 able to effect ~5000-fold reduction in viral RNA at 48 h. Ivermectin therefore warrants further investigation for possible benefits in humans. Ivermectin is not approved for Covid-19 by the European Medicines Agency (EMA) or the American Food and Drug Administration (FDA). On March 22, 2021 EMA advises against use of ivermectin for the prevention or treatment of COVID-19 outside randomised clinical trials [248].

von EMA und FDA nicht für covid-19 zugelassen

Empfehlung GEGEN einen Anwendung außerhalb von klinischen Studien

The **US COVID-19 Treatment Guidelines Panel** Statement (February 11, 2021) [86] [151] is: Currently there are **insufficient data** to **recommend either for or against** the use of ivermectin for the treatment of COVID-19. Results from adequately powered, well-designed, and well-conducted clinical trials are needed to provide more specific, evidence-based guidance on the role of ivermectin for the treatment of COVID-19.

US COVID-19 Treatment Guidelines Panel: insuffiziente Datenlage, nur in klinischen Studien

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated interventional studies were found on ivermectin in COVID-19 patients in ClinicalTrials.gov and EUdraCT registers.

keine abgebrochenen oder zurückgezogenene Studien

Results of publications

Several RCTs compared **ivermectin vs standard care**, published in scientific journals or as preprint, showed positive or negative results on different clinical outcomes in COVID-19 patients [249-254]. **Podder et al. 2020** [249] published negative results from single-centre, open-label, randomised controlled trial in 62 mild to moderate COVID-19 patients. Total recovery time from the onset of symptoms to complete resolution of symptoms was not significantly different (intervention arm 10.09 ± 3.236 days, compared to 11.50 ± 5.32 days in the control arm (95% CI -0.860,3.627, p>0.05). The same was true for results of negative repeat RT- PCR.

mehrere RCTs

RCT, 62 Pts. milde bis moderate Krankheit

kein Unterschied

Krolewiecki et al. 2020 [250] published positive results from a pilot, randomised, controlled, outcome-assessor blinded clinical trial with the goal of evaluating the antiviral activity of high dose ivermectin in **mild or moderate COVID-19** patients (NCT004381884). 45 patients were randomized in a 2:1 ratio to standard of care plus oral ivermectin at 0.6 mg/kg/day for 5 days versus standard of care. There was no difference in viral load reduction between groups but a significant difference in reduction was found in patients with higher median plasma ivermectin levels (72% IQR 59 – 77) versus untreated controls (42% IQR 31 – 73) (p=0.004). The mean ivermectin plasma concentration levels also showed a positive correlation with viral decay rate (r:0.47, p=0.02). Adverse events were reported in 5 (33%) patients in the controls and 13 (43%) in the ivermectin treated group, without a relationship between ivermectin plasma levels and adverse events.

RCT, 45 Pts. milde bis moderate Krankheit
kein Unterscheid bei Viruslastreduktion, aber bei Pts. mit höherPlasma Konzentration

Ahmed et al. 2020 [251] published positive results from randomised, double-blind, placebo-controlled trial in 72 **hospitalised** adult SARS-CoV-2 patients who were assigned to one of three groups: oral ivermectin alone (12 mg once daily for 5 days), oral ivermectin in combination with doxycycline (12 mg ivermectin single dose and 200 mg doxycycline on day 1, followed by 100 mg every 12 h for the next 4 days), and a placebo control group. Clinical symptoms of fever, cough, and sore throat were comparable among the three groups. Virological clearance was earlier in the 5-day ivermectin treatment arm when compared to the placebo group (9.7 days vs 12.7 days; p=0.02), but this was not the case for the ivermectin + doxycycline arm (11.5 days; p=0.27). There were no severe adverse drug events recorded in the study.

RCT, 72 Pts, hospitalisiert

klinische Symptome: kein Unterschied
gewisse zeitlcie Verkürzung der Viruslast

Chachar et al. 2020 [252] published negative results from open label randomised control tria in 50 **mild COVID-19** patients, divided into two groups: Ivermectin group received 12mg stat and then 12 mg after 12 hours and 12mg after 24 hours, and control group. There was no significant difference on outcome improvement of symptoms between case group who were given ivermectin along with symptomatic treatment and control group who were only given symptomatic treatment without ivermectin, on day 7 at follow up (p=0.500).

RCT, 50 Pts. milde Erkrankung

kein Unterschied

Niaee et al. 2020 [253] published positive results from 45-days randomised, double-blind, placebo-controlled, multicenter, phase 2 clinical trial in 180 **mild to severe hospitalised COVID-19** patients (IRCT20200408046987N1). The participants were randomly allocated to six arms including common regimens (Hydroxychloroquine 200mg/kg twice per day), placebo plus common regime, single dose ivermectin (200mcg/Kg, 1 pill per day), three low interval doses of ivermectin (200, 200, 200 mcg/Kg , 3 pills in 1, 3 and 5 interval days), single dose ivermectin (400mcg/Kg, 2 pills per day), and three high interval doses of ivermectin (400, 200, 200 mcg/Kg, 4 pills in 1, 3 and 5 interval days). Ivermectin significantly reduced the rate of mortality, low O2 duration, and duration of hospitalization in adult COVID 19 patients.

RCT, 180 Pts. mild bis schwere Erkrankung, hospitalisiert

Vorteile bei Mortalität, Dauer der Hospitalisierung

Babalola et al. 2021 [254] published results from a translational proof of concept randomised, double blind placebo controlled, dose response, parallel group study of ivermectin efficacy in RT - PCR proven **mild to moderate COVID 19** positive patients (ISRCTN40302986). 62 patients were randomised to 3 treatment groups: ivermectin 6mg regime; ivermectin 12 mg regime (given Q84hrs for 2weeks); control group Lopinavir/Ritonavir. All groups plus standard of care. The Days to COVID negativity [DTN] was

RCT, 62 Pts, milde bis moderate Erkrankung

Reduktion der Erkrankungsdauer

significantly and dose dependently reduced by ivermectin (p=0.0066). 12 mg ivermectin regime may have superior efficacy.

Ravikirti et al. 2021 [255] published as preprint results from RCT in adult patients with **mild to moderate COVID-19** in India (randomised to ivermectin 12 mg on day 1 and day 2 of admission or placebo) (CTRI/2020/08/027225). A total of 115 patients were enrolled for the study of which 112 were included in the final analysis. Of them, 55 were randomised to the intervention arm while 57 were randomised to the placebo arm. There was no significant difference in the primary outcome, i.e. negative RT-PCR status on day 6 between the two groups and in most of the secondary outcome measures, symptom status on day 6, discharge status on day 10, admission to ICU, and need for invasive mechanical ventilation. There was no in-hospital mortality in the intervention arm, there were 4 deaths in the placebo arm. As a result, all patients in the intervention arm (n=56) were successfully discharged as compared to 93.1% (n=54/58) in the placebo arm (RR 1.1, 95% CI 1.0 to 1.2, p=0.019).

RCT (Indien)
115 Patient*innen

keine Unterschiede in verschiedenen Endpunkten

ev. bei Mortalität

Lopez-Medina et al. 2021 [256] published negative results from double-blind, randomized trial conducted at a single site in Colombia (NCT04405843). Patients with **mild COVID-19** were randomized to receive ivermectin, 300 µg/kg of body weight per day for 5 days (n = 200) or placebo (n = 200). A 5-day course of ivermectin, compared with placebo, did not significantly improve the time to resolution of symptoms. The most common solicited adverse event was headache, reported by 104 patients (52%) given ivermectin and 111 (56%) who received placebo. The most common serious adverse event was multiorgan failure, occurring in 4 patients (2 in each group).

1 RCT (Kolumbien)
400 Pts
milde Erkrankung
negative Ergebnisse: kein Unterschied

Mohan et al. 2021 published as preprint negative results from RCT conducted in 157 **mild to moderate COVID-19** patients (CTRI/2020/06/026001) [257]: patients were randomized to elixir formulation of ivermectin in 24 mg, 12 mg or placebo in 1:1:1 ratio. 125 patients were included in mITT analysis. Forty patients each were assigned to ivermectin 24 mg and 12 mg, and 45 patients to placebo. The RT-PCR negativity at day 5 was not statistically significant different compared to placebo (ivermectin 24 mg, 47.5%; 12 mg, 35.0%; and placebo, 31.1%; p=0.30). The decline of viral load at day 5 was similar in the three arms. No serious adverse events were encountered.

1 RCT (Indien)
157 Pts.
milde/ moderate Erkrankung
negative Ergebnisse: kein Unterschied

Okumus et al. 2021 [258] published as preprint results from RCT conducted in **severe COVID-19** patients in Turkey (36 patients received ivermectin 200 mcg/kg/day for five days vs reference treatment in 30 patients). Clinical outcomes were not statistically significant different compared to standard treatment: Clinical improvement: 22/30 (73.3%) compared to the control group 16/30 (53.3%), (p=0.10) and Mortality: 6 patients (20%) in the study group and in 9 (30%) patients in the control group (p=0.37).

1 RCT (Türkei)
66 Pts.
schwere Erkrankung
negative Ergebnisse: kein Unterschied

Shah Bukhari et al. 2021 [259] published as preprint results from RCT (NCT04392713) conducted in mild to moderate COVID-19 patients treated with ivermectin (single dose of 12 milligrams) along with standard of care treatment (n=50) vs standard of care (n=50). There was early viral clearance in ivermectin group as compared to group received standard of care (p=0.001). No adverse reaction was noted in the intervention arm during the trial period.

1 RCT (Pakistan)
100 Pts.
milde/ moderate Erkrankung
Vorteil von Ivermectin

Gonzales et al. 2021 [260] published as preprint results from RCT on patients with COVID-19-induced pneumonia and hospitalization criteria, but no severe respiratory failure. Patients were randomized to one of three groups: Group1-hydroxychloroquine, 400 mg every 12 hours on the first day and subsequently, 200 mg every 12 hours for 4 days, Group 2-ivermectin, 12 mg or

1 RCT
kein Unterschied

18 mg, according to patient weight and, Group 3-placebo. No difference in hospitalization duration was found between the treatment groups (Group1: 7 vs Group 2: 6 vs Group 3: 5, p=0.43) nor in respiratory deterioration or death (Group 1: 18 % vs Group 2: 22.2 % vs Group 3: 24.3 %, p =0.83).

1 RCT
raschere Reduktin der Viruslast

Pott-Junior et al. 2021 [261] reported results from RCT on 32 mild COVID-19 patients (received standard of care (SOC) treatment at hospital admission; SOC plus ivermectin 100 mcg/kg; SOC plus ivermectin 200 mcg/kg; or SOC plus ivermectin 400 mcg/kg. All patients exhibited a reduction in SARS-CoV-2 viral load within 7 days; those who received ivermectin had a more consistent decrease as compared to the SOC alone group, characterized by a shorter time for obtaining two consecutive negative SARS-CoV-2 RT PCR tests. No serious adverse events were reported.

eine Metaanalyse und Zusammenfassung der Ergebnisse:

niedrige Evidenz, große Unsicherheit

The meta-analysis and **Summary of findings table** related to **ivermectin vs standard care** is provided in Table 3.27-1 below. In summary, according to very low certainty of evidence, does ivermectin decrease all-cause mortality D28 compared to standard of care/placebo is very uncertain (RR 0.38, 95% CI 0.13 to 1.12, 8 RCTs). The same is true for the outcome viral negative conversion D7 (RR 1.03, 95% CI 0.88 to 1.21m 9 RCTs). According to moderate certainty of evidence, ivermectin does not increase clinical improvement D28 (RR1.00, 95% CI 0.91 to 1.11, 4 RCTs). According to high certainty of evidence, ivermectin does not increase adverse events (RR 0.94, 95% CI 0.84 to 1.06, 8 RCTs). According to very low certainty of evidence, does ivermectin increase serious adverse events, compared to standard of care/placebo, is very uncertain (RR 1.92, 95% CI 0.46 to 8.04, 7 RCTs).

Table 3.27-1: Summary of findings table on Ivermectin compared to Standard Care/Placebo for Mild/Moderate(Severe/Unclear COVID-19 (12 RCTs: Shah Bukari; Khan Chachar; Ahmed; Chaccour; Mohan; Podder; Kirti, Krolewiecki, Niaee, Okumus, Beltran-Gonzales, Pott-Junior) – https://covid-nma.com/living_data/index.php

Ivermectin compared to Standard Care/Placebo for Mild/Moderate/Severe/Unclear COVID-19
Patient or population: Mild/Moderate/Severe/Unclear COVID-19
Setting: Worldwide
Intervention: Ivermectin
Comparison: Standard Care/Placebo

Outcomes	Anticipated absolute effects* (95% CI)		Relative effect (95% CI)	№ of participants (studies)	Certainty of the evidence (GRADE)	Comments
	Risk with Standard Care/Placebo	Risk with Ivermectin				
Viral negative conversion D7	438 per 1,000	**451 per 1,000** (385 to 530)	**RR 1.03** (0.88 to 1.21)	502 (9 RCTs) [b]	⨁◯◯◯ VERY LOW [c,d]	
Clinical improvement D28	756 per 1,000	**756 per 1,000** (688 to 839)	**RR 1.00** (0.91 to 1.11)	390 (4 RCTs) [e]	⨁⨁⨁◯ MODERATE [f,g]	
Clinical improvement D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
WHO Progression Score (level 7 or above) D28	3 per 1,000	**5 per 1,000** (1 to 36)	**RR 1.82** (0.27 to 12.23)	745 (5 RCTs) [h]	⨁⨁◯◯ LOW [i]	
WHO progression score (level 7 or above) D60 or more - not reported	-	-	-	-	-	outcome not yet measured or reported
All-cause mortality D28	38 per 1,000	**15 per 1,000** (5 to 43)	**RR 0.38** (0.13 to 1.12)	1113 (8 RCTs) [j]	⨁◯◯◯ VERY LOW [j,k]	
All-cause mortality D60 or more	300 per 1,000	**168 per 1,000** (66 to 414)	**RR 0.56** (0.22 to 1.38)	66 (1 RCT) [l]	⨁◯◯◯ VERY LOW [l,m,n]	
Adverse events	502 per 1,000	**472 per 1,000** (422 to 533)	**RR 0.94** (0.84 to 1.06)	893 (8 RCTs) [o]	⨁⨁⨁⨁ HIGH [p]	
Serious adverse events	5 per 1,000	**10 per 1,000** (2 to 41)	**RR 1.92** (0.46 to 8.04)	861 (7 RCTs) [q]	⨁◯◯◯ VERY LOW [l,r]	

*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the relative effect of the intervention (and its 95% CI).

CI: Confidence interval; **RR**: Risk ratio

GRADE Working Group grades of evidence High certainty: We are very confident that the true effect lies close to that of the estimate of the effect; **Moderate certainty:** We are moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different; **Low certainty:** Our confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect; **Very low certainty:** We have very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect

Explanations: a. Last updated: April 13, 2021; b. Shah Bukari KH, 2021; Khan Chachar AZ, 2020; Ahmed S, 2020; Chaccour C, SAINT, 2020; Mohan A, 2021; Podder C, 2020; Kirti R, 2021; Okumus N, 2021, Pott-Junior H, 2021; c. Risk of bias downgraded by 2 levels: high risk of bias due to inadequate randomization and missing data, some concerns regarding deviations from intended interventions and selection of reported results.; d. Imprecision downgraded by 1 level: due to low number of events and/or participants; e. Khan Chachar AZ, 2020; Mohan A, 2021, Kirti R, 2021, Beltran-Gonzalez J, 2021; f. Risk of bias downgraded by 1 level due to high risk or some concerns regarding adequate randomization, outcome measurement and selection of the reported result; g. One additional study was identified that measured this outcome but no results were reported; h. Lopez-Medina E, 2021; Ahmed S, 2020; Chaccour C, SAINT, 2021; Mohan A, 2021; Krolewiecki A, 2020; i. Imprecision downgraded by 2 levels: due to very wide confidence interval consistent with the possibility for benefit and the possibility for harm and low number of participants and events.; j. Lopez-Medina E, 2021; Ahmed S, 2020; Chaccour C, SAINT, 2021; Mohan A, 2021; Krolewiecki A, 2020; Kirti R, 2021; Beltran-Gonzalez J, 2021; Niaee MS, 2020; k. Risk of bias downgraded by 1 level: some concerns regarding adequate randomization, deviations from intended interventions and selection of reported results; l. Okumus N, 2021; m. Risk of bias downgraded by 1 level: high risk of bias due to randomization and some concerns with deviation from intended intervention.; n. Indirectness downgraded by 1 level: despite a multicentre design, results are mainly from a single study from a single country, therefore results in this population might not be generalizable to other settings.; o. Lopez-Medina E, 2021; Khan Chachar AZ, 2020; Ahmed S, 2020; Chaccour C, SAINT, 2021; Mohan A, 2021; Krolewiecki A, 2020, Okumus N, 2021, Pott-Junipr H, 2021; p. Despite concern regarding sequence generation, deviation from intended interventions, outcome measurement and selection of reported results not downgraded for risk of bias because the studies with these concerns contributed only a small proportion of the data; q. Lopez-Medina E, 2021; Khan Chachar AZ, 2020; Ahmed S, 2020; Chaccour C, SAINT, 2021; Mohan A, 2021; Krolewiecki A, 2020, Okumus N, 2021; r. Risk of bias downgraded by 1 level: some concerns or high risk regarding adequate randomization, deviations from intended interventions, and outcome measurement.

3.28 Aspirin (acetylsalicylic acid)

About the drug under consideration

Aspirin (acetylsalicylic acid) is a non-steroidal anti-inflammatory drug with strong anti-inflammatory, anti-thrombotic and analgesic pharmacological effects. Long-term low-dose aspirin (75-150 mg daily) can effectively prevent the incidence of ischaemic cardiovascular and cerebrovascular event. Acetylsalicylic acid inhibits the platelet activation: blocking the platelet cyclooxygenase by acetylation, it inhibits thromboxane A2 synthesis, a physiological activating substance released by the platelets and which would play a role in the complications of the atheromatosic lesions. The repeated doses from 20 to 325 mg involve an inhibition of the enzymatic activity from 30 to 95%. Due to the irreversible nature of the binding, the effect persists for the lifespan of a thrombocyte (7-10 days). The inhibiting effect does not exhaust during prolonged treatments and the enzymatic activity gradually begins again upon renewal of the platelets 24 to 48 hours after treatment interruption, https://www.medicines.org.uk/emc/product/2408/smpc.

nicht-steroidales Antirheumatikum

schmerzstillender, entzündungshemmender, fiebersenkender und Thrombozyten-aggregationshemmender Arzneistoff

Patients with COVID-19 are at higher risk of blood clots forming in their blood vessels. Platelets, small cell fragments in the blood that stop bleeding, seem to be hyperreactive in COVID-19 and may be involved in the clotting complications. Since aspirin is an antiplatelet agent, it may reduce the risk of blood clots in patients with COVID-19.

Patient*innen mit Covid-19 haben höheres Risiko für Bildung von Blutgerinnseln in Blutgefäßen

Chow et al. 2020 [262] published results from retrospective, observational cohort study of adult patients admitted with COVID-19 to multiple hospitals in the United States between March 2020 and July 2020. 412 patients were included in the study. 314 patients (76.3%) did not receive aspirin, while 98 patients (23.7%) received aspirin within 24 hours of admission or 7 days prior to admission. Aspirin use had a crude association with less mechanical ventilation (35.7% aspirin vs. 48.4% non-aspirin, p=0.03) and ICU admission (38.8% aspirin vs. 51.0% non-aspirin, p=0.04), but no crude association with in-hospital mortality (26.5% aspirin vs. 23.2% non-aspirin, p=0.51). After adjusting for 8 confounding variables, aspirin use was independently associated with decreased risk of mechanical ventilation (adjusted HR 0.56, 95% CI 0.37-0.85, p=0.007), ICU admission (adjusted HR 0.57, 95% CI 0.38-0.85, p=0.005), and in-hospital mortality (adjusted HR 0.53, 95% CI 0.31-0.90, p=0.02). There were no differences in major bleeding (p=0.69) or overt thrombosis (p=0.82) between aspirin users and non-aspirin users. Authors concluded that a sufficiently powered randomized controlled trial is needed to assess whether a causal relationship exists between aspirin use and reduced lung injury and mortality in COVID-19 patients.

retrospektive Kohortenstudie, 412 Pts

Vorteile bei künstlicher Beatmung und Intensivmedizin Spitalsmortalität

RCT für Nachweis einer Kausalität vonnöten

Aspirin is not approved for Covid-19 by the European Medicines Agency (EMA) or the American Food and Drug Administration (FDA).

Withdrawn, suspended or terminated studies

One RCT was found as withdrawn (NCT04343001) because grant not obtained. No suspended or terminated interventional studies were found on Aspirin in COVID-19 patients in ClinicalTrials.gov and EUdraCT registers.

1 RCT zurückgezogen (keine Finanzierung)

Results of publications

There are no published RCTs related to effectiveness and safety of Aspirin for Covid-19.

bislang keine RCTs veröffentlicht, aber klinische Untersuchung in RECOVERY

From 06 November 2020, Aspirin is being investigated in the world's largest clinical trial of treatments for patients hospitalised with COVID-19. The Randomised Evaluation of COVid-19 thERapY (**RECOVERY**) trial is taking place in 176 hospital sites across the UK, and has so far recruited over 16,000 patients, https://www.recoverytrial.net/news/aspirin-to-be-investigated-as-a-possible-treatment-for-covid-19-in-the-recovery-trial. It is anticipated that at least 2,000 patients will be randomly allocated to receive **Aspirin 150 mg daily plus usual standard-of-care**, and results will be **compared** with at least 2,000 patients who receive **standard-of-care** on its own. Patients will not be allocated to receive Aspirin if they have a known hypersensitivity to Aspirin; if they have experienced recent major bleeding or if they already take Aspirin or other antiplatelet agents. The main outcome RECOVERY will assess is mortality after 28 days. Other outcomes include the impact on hospital stay and the need for ventilation. It is likely to be several months before there is enough evidence to conclude whether Aspirin has a significant benefit in COVID-19 patients.

Studienarm mit Aspirin 2.000 Pts vs. SoC geplant

Ergebnisse erst in einigen Monaten zu erwarten

3.29 Aviptadil (RLF-100)

About the drug under consideration

Aviptadil (RLF-100) is a synthetic form of Human Vasoactive Intestinal Polypeptide (VIP). VIP acts on two receptors - VPAC1 and VPAC2, which are class B of G-protein-coupled receptors (GPCRs). Aviptadil is found to reduce viral replication in lung tissues, release of inflammatory cytokines and alveolar epithelial cell apoptosis in patients with corona virus infection. It is available both as intra venous and inhalational (nebulisation) preparations. It is found useful in conditions like asthma, chronic obstructive pulmonary disease (COPD), sarcoidosis, pulmonary fibrosis, acute lung injury, pulmonary hypertension, erectile dysfunction and ARDS. Intra venous administration is associated with side effects like tachycardia, flushing, hypotension, diarrhoea and alterations in ECG (bigeminy) [263]. Recent observational studies showed that treatment with aviptadil is associated with rapid recovery in Corona virus infected critically ill patients [263-266]. Aviptadil is not authorised in Covid-19 patients (EMA, FDA). On 14 July 2020 FDA granted Investigational New Drug (IND) permission for inhaled VIP and awarded FDA Orphan Drug Designation for intravenous VIP, to use in patients with COVID-19.

synthetisches menschliches vasoaktives intestinales Polypeptid (VIP)

soll Replikation des SARS-CoV-2-Virus in menschlichen Lungenzellen und Monozyten blockieren

Withdrawn, suspended or terminated studies

No withdrawn, suspended or terminated studies were found. Two randomised controlled trials are ongoing with inhaled aviptadil.

2 laufende RCTs mit inhaltivem Aviptadil

In one RCT nebulized RLF-100 (aviptadil) 100 µg is given 3 times daily for moderate and severe COVID-19, with estimated enrolment of 288 patients (NCT04360096- AVICOVID-2). Another RCT with inhaled aviptadil with

estimated enrolment in 80 patients in Switzerland (NCT04536350) is not yet recruiting patients.

Expanded Access Protokoll zur Verwendung von Aviptadil

In one study related to Expanded access protocol (NCT04453839, SAMICARE), aviptadil is given as 12 hour infusions at ascending doses of 50/100/150 pmol/kg/hr on 3 successive days. This expanded access protocol is designed to offer access to investigational use of RLF-100 to patients who do not qualify for inclusion in NCT04311697 either on the basis of specific medical exclusions or because there is no accessible study site available to the prospective participant.

Results of publications

keine publizierten Ergebnisse der RCTs

Pressemeldung zu Ergebnissen von 2b/3 RCT: 196 Pts.

schnellere klinische Verbesserung/ Erholung vom Lungenversagen

Einreichung zur Notfallzulassung bei FDA

Currently, no published results were found from RCT. On March 29, 2021 NeuroRx, Inc. reports 60-day results of the completed phase 2b/3 RCT (NCT04311697 - COVID-AIV) of intravenously-administered ZYESAMI™ (aviptadil acetate, given as escalating doses from 50 -150 pmol/kg/hr over 12 hours for 3 days) for the treatment of respiratory failure in critically-ill patients with COVID-19. Across all 196 treated patients and all 10 clinical sites, aviptadil met the primary endpoint for successful recovery from respiratory failure at days 28 ($p=0.014$) and 60 ($p=0.013$) and also demonstrated a meaningful benefit in survival ($p<0.001$) after controlling for ventilation status and treatment site. In addition, the prespecified analysis of recovery from respiratory failure is clinically and statistically significant in the 127 patients treated by High Flow Nasal Cannula (HFNC) ($p=0.02$), compared to those treated with mechanical or non-invasive ventilation at tertiary care hospitals. In this group aviptadil patients had a 71% chance of successful recovery by day 28 vs. 48% in the placebo group ($p=0.017$) and a 75% rate of successful recovery by day 60 vs. 55% in the placebo group ($p=0.036$). Eighty-four percent (84%) of HFNC patients treated at tertiary medical centers with aviptadil survived to day 60 compared with 60% of those treated with placebo ($p=0.007$), https://www.prnewswire.com/news-releases/neurorx-announces-zyesami-aviptadil-rlf-100-met-the-primary-endpoint-of-its-phase-2b3-clinical-trial-and-also-demonstrated-a-meaningful-benefit-in-survival-from-critical-covid-19-301257291.html. On the basis of these findings, NeuroRx immediately applied to the United States Food and Drug Administration ("FDA") for Emergency Use Authorization (EUA).

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