From
Director General Health Services, Haryana

To
Keepers of all private Medical Colleges/
Hospitals in Haryana, providing COVID-19 related treatment.

Memo No. HMD/2021/1296-1495  Dated: 04.05.2021

Subject: Guidelines regarding distribution of TOCILIZUMAB available in the State to individual COVID patient.

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In continuation of State Government Order No. 3PM-
2(COVID)/2021/1373-1398 dated 30.04.2021 regarding constitution of an expert Committee to decide on the distribution of Tocilizumab available in the State to individual COVID patient in public/ private health institutions on clinically approved evidence-based grounds and ethical principle of distributive justice, to maintain equity and transparency.

The Committee prescribed the steps to approve Tocilizumab for the treatment of COVID-19 patients, as follows:

1. **No** Doctor/Hospital shall issue prescription for TOCILIZUMAB, for purchase of same from anywhere, as distribution of drug is controlled by Govt.
2. **Application:** All the COVID Hospitals requiring Tocilizumab for treatment of COVID-19 patients shall apply to the Committee on e-mail toci.haryana@gmail.com.
3. The application will be the Proforma (Annexure-A). No application without filled Proforma or incomplete Proforma will be entertained
4. Technical Committee will meet twice every day at 10/11 AM in the morning and 4/5 PM in the evening through virtual/ digital platform.
5. The O/o DHS, MSD will convene the meeting and coordinate with technical committee & facilitate the rapid decision making as time is essence; and also monitor overall management of drug from approval till delivery to concerned hospital.
6. All the applications received will be scrutinized.
7. The decision of each meeting will be conveyed to all the stakeholders and a copy would be displayed at the website of Health Department.
8. The approved applicant hospital shall deposit the charges for the injection to the concerned Civil Surgeon.
9. Reasons for refusal will be written and informed to the requisitioning hospitals/physicians.
10. O/o DHS (MSD) will maintain all the record.
11. The concerned Civil Surgeon would issue the drug to authorized person of concerned hospital.
12. The amount so collected would be deposited in the SKS Account.
13. All the Civil Surgeons will ensure the issuance of drug on same day, store to be open 24x7.
14. O/o DHS (MSD) in coordination with HMSCL (Dr. Navjot- 9815916295) will ensure drug distribution in future as well, after approval of worthy ACS, Health Department.
15. The concerned hospital will submit report regarding usage of drug for the approved patient only.
16. It shall be the personal responsibility of the hospital administrator of the institutes requisitioning Tocilizumab to ensure appropriate use of prescription medicine, coordination with health authorities and to keep proper records so that they are available for audit purpose later.
17. In case Tocilizumab is issued & patient dies, then the concerned hospital shall reimburse the amount to patient and keep the drug in stock for use if approved case in future. However, concerned Civil Surgeon shall be informed.

Director General Health Services, Haryana

Endst. No.: HMD/2021/1496-1546

Dated: 04.05.2021

A copy is forwarded to the following for necessary action:

1. Additional Chief Secretary to Govt. of Haryana (MER)
2. APS/ Hon’ble Chief Minister, Haryana
3. Managing Director, HMSCL, Haryana
4. Mission Director, National Health Mission, Haryana
5. All the Deputy Commissioners of State
6. All the Civil Surgeons of State
7. DD(IT) O/o DGHS with a request to publish the same on website of Health Department.
8. PS to Hon’ble Health Minister, Haryana
9. PS to Chief Secretary to Govt. of Haryana
10. PS to Additional Chief Secretary to Govt. of Haryana (Health)

Director General Health Services, Haryana
GOVERNMENT OF HARYANA
DEPARTMENT OF HEALTH & FAMILY WELFARE
SOPs for Technical Board to decide about Tocilizumab

Only a multidisciplinary team or 3 members team consisting of physician involved in COVID patient care (to be signed by at least two) can recommend the use of Tocilizumab/immunomodulator therapy.
The following parameters have to be considered and recorded:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes/No</th>
<th>Condition</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Rapid deterioration</td>
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<td>Coexistent infection other than COVID-19</td>
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<tr>
<td>RR &gt; 30 bpm</td>
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<td>PaO2/FIO2 &gt; 300 mm Hg; chronic glucocorticoid use</td>
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<tr>
<td>SaO2 &lt; 93% on room air &amp; CRP &gt; 75 mg/L</td>
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<td>H/O another IL6 inhibitor in present admission</td>
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<tr>
<td>PaO2/FIO2 &lt; 300 mm Hg in room air, and</td>
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<td>H/O severe allergic reactions to monoclonal antibodies</td>
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<td>Lung infiltrates &gt; 50% within 24-48 h</td>
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<td>ANC &lt; 500 per μL; platelets &lt; 50×10⁹</td>
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<td>Invasive or noninvasive mechanical ventilation, including through HFNC with flow &gt; 30 l/min &amp; FiO2 &gt; 0.4</td>
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<td>Active diverticulitis, IBD, or another symptomatic gastrointestinal tract condition that might predispose patients to bowel perforation</td>
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<td>Vasopressor or inotrope</td>
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<td>Severe haematological, renal, or liver function impairment.</td>
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<table>
<thead>
<tr>
<th>Investigations</th>
<th>Result</th>
<th>Condition</th>
<th>Result</th>
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<tbody>
<tr>
<td>CRP</td>
<td>S Creatinine</td>
<td>CT severity score (if available)</td>
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<tr>
<td>SGOT/SGPT</td>
<td>S Procalcitonin (if available)</td>
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<td>Blood culture (if available)</td>
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This is certified that
Mr/Ms/Mrs.................................................. 
S/O/D/o/W/o..................................................
Aged........ yrs
Address ..........................................................
Institution ........................................ City.......Distt...........Haryana.
Hospital ID No............................... DOA...................(DD/MM/Year) is suffering from COVID-19 and is found to be an eligible candidate for Tocilizumab (............ mg)

Treating hospital contact person:
Name | Contact No | Email |
|------|------------|-------|

Intensivist/ Anaesthesiologist  [Signature]
Physician/ Respiratory physician [Signature]

Place: [Place]
Date: [Date]