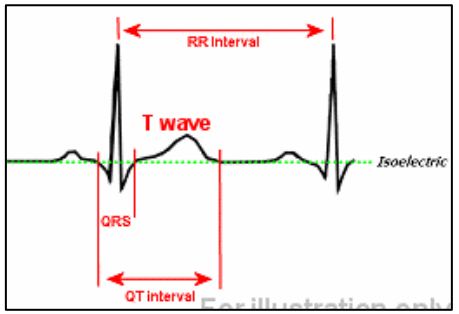
**Baseline Risk Assessment of $QT_c$ Prior to Initiation of COVID-19 Therapies***

- Preferable to assess $QT_c$ with a standard, 12-lead ECG; however, telemetry recordings will be acceptable.
- ECGs obtained within the past 12 months will be acceptable to evaluate QT if the patient has not developed CV disease or initiated a QT prolonging medication in the interim.

**When QRS <120 ms, the corrected QT ($QT_c$) = QT (ms) /$\sqrt{RR}$ (sec)**
**When QRS ≥120 ms, $QT_c$ = (QT-QRS duration (ms) + 100 ms) /$\sqrt{RR}$ (sec)**

* *Low risk patients do not require a baseline QTc assessment and can have potential QT-prolonging therapies initiated without an ECG. Low risk patients are defined by a) age < 65 years, b) no history of CV disease or ventricular dysfunction, c) no history of long QT syndrome, d) not taking a QT prolonging med (www.crediblemeds.com); and e) are not in acute renal failure.*




Electrolyte Repletion
K > 4mg/dL; Mg > 2.0 mg/dL

Eliminate other QT prolonging drugs

Normal baseline QT (QTc < 460 ms)

Can start potential QT prolonging, COVID 19 therapy with low risk

QTc 460- 490 ms

Cardiac monitoring recommended

Can start potential QT prolonging COVID 19 therapy and record ECG/telemetry 2 hours after first 2 doses.

Prolonged $QT_c$ > 490 ms

High risk for Torsades de Pointes/VT. Need to weigh risk /benefit of therapy.

If therapy is initiated, continue to monitor.

**Continue Therapy if $QT_c$ < 500 ms or if $QT_c$ increases by ≤ 50 ms**

**STOP Therapy**
- **$QT_C$ > 550 ms**
- **$QT_c$ inc > 50 ms**
- **VT / VF**

**Other Recommendations**
Consider extended, mobile cardiac outpatient telemetry (MCOT) monitoring for selected COVID-19 patients that have other high-risk features for cardiac arrhythmias including family history of sudden cardiac death, elevated troponin, or elevated NT-pro BNP.