

## **RAND PANEL STATEMENTS**

### **Patients with COVID-19 Crohn's Disease and COVID-19 Ulcerative Colitis**

#### **Summary of Statements**

*These statements represent the summation of expert opinion and should be interpreted in the context of the individual patient and the managing healthcare provider who knows her or him. These are not guidelines and these may be updated as knowledge and the situation evolve.*

1. The risk of infection with SARS-CoV-2 is the same whether a patient has IBD or does not have IBD.
2. Independent of treatment, patients with Crohn's disease do not have a greater risk of infection with SARS-CoV-2 than the general population.
3. Independent of treatment, patients with ulcerative colitis do not have a greater risk of infection with SARS-CoV-2 than the general population.
4. It is uncertain if active inflammation from IBD increases the risk of getting SARS-CoV-2.
5. It is uncertain if patients with IBD who are exposed to SARS-CoV-2 have a higher risk of developing COVID-19 compared to patients without IBD.
6. It is uncertain if patients with IBD who develop COVID-19 have a higher mortality compared to patients without IBD.
7. Patients with an ostomy are not at increased risk for COVID-19.
8. Patients with a J pouch are not at increased risk for COVID-19.
9. Elective surgeries and endoscopies should be postponed at this time.
10. It is uncertain if healthcare workers with IBD on immune modifying medications working in an environment with known or suspected COVID-19 patients should continue working in that same environment.
11. Patients with IBD on immune modifying medications should discontinue any non-essential travel.
12. It is safe to continue infusions in an infusion center, assuming the infusion center has a screening protocol in place.
13. 5-ASA does not increase the risk of infection with SARS-CoV-2.
14. 5-ASA does not increase the risk of COVID-19.
15. Patients taking 5-ASA therapy should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
16. Patients taking 5-ASA therapy should not discontinue therapy to prevent SARS-CoV-2 infection.
17. Patients taking 5-ASA therapy should not stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.
18. Patients taking 5-ASA therapy should not stop therapy if they develop COVID-19.
19. Budesonide does not increase the risk of infection with SARS-CoV-2.
20. Budesonide does not increase the risk of COVID-19.
21. Patients taking budesonide therapy should not reduce the dose of therapy to prevent SARS-CoV-2 infection.

22. Patients taking budesonide therapy should not discontinue therapy to prevent SARS-CoV-2 infection.
23. It is uncertain if patients taking budesonide therapy should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.
24. It is uncertain if patients taking budesonide therapy should stop therapy if they develop COVID-19.
25. Prednisone ( $\geq 20$ mg/d) increases the risk of infection with SARS-CoV-2.\*
26. Prednisone ( $\geq 20$ mg/d) increases the risk of COVID-19.\*
27. Patients taking prednisone therapy ( $\geq 20$ mg/d) should reduce the dose of therapy to prevent SARS-CoV-2 infection.
28. Patients taking prednisone therapy ( $\geq 20$ mg/d) should discontinue therapy (taper as appropriate) to prevent SARS-CoV-2 infection.\*
29. Patients taking prednisone therapy ( $\geq 20$ mg/d) should stop therapy (taper as appropriate) if they test positive for SARS-CoV-2 but don't have COVID-19.
30. Patients taking prednisone therapy ( $\geq 20$ mg/d) should stop therapy (taper as appropriate) if they develop COVID-19.
31. It is uncertain if azathioprine/6-MP increases the risk of infection with SARS-CoV-2.
32. It is uncertain if azathioprine/6-MP increases the risk of COVID-19.
33. Patients taking azathioprine/6-MP should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
34. Patients taking azathioprine/6-MP should not discontinue therapy to prevent SARS-CoV-2 infection.
35. Patients taking azathioprine/6-MP should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.
36. Patients taking azathioprine/6-MP should stop therapy if they develop COVID-19.
37. It is uncertain if methotrexate increases the risk of infection with SARS-CoV-2.
38. It is uncertain if methotrexate increases the risk of COVID-19.
39. Patients taking methotrexate should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
40. Patients taking methotrexate should not discontinue therapy to prevent SARS-CoV-2 infection.
41. Patients taking methotrexate should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.\*
42. Patients taking methotrexate should stop therapy if they develop COVID-19.
43. It is uncertain if anti-TNF therapy increases the risk of infection with SARS-CoV-2.
44. It is uncertain if anti-TNF therapy increases the risk of COVID-19.
45. Patients taking anti-TNF therapy should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
46. Patients taking anti-TNF therapy should not discontinue therapy to prevent SARS-CoV-2 infection.
47. It is uncertain if patients taking anti-TNF therapy should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.
48. Patients taking anti-TNF therapy should stop therapy if they develop COVID-19.
49. Vedolizumab does not increase the risk of infection with SARS-CoV-2.
50. Vedolizumab does not increase the risk of COVID-19.
51. Patients taking vedolizumab should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
52. Patients taking vedolizumab should not discontinue therapy to prevent SARS-CoV-2 infection

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53. It is uncertain if patients taking vedolizumab should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.
  54. It is uncertain if patients taking vedolizumab should stop therapy if they develop COVID-19.
  55. Ustekinumab does not increase the risk of infection with SARS-CoV-2.
  56. Ustekinumab does not increase the risk of COVID-19.
  57. Patients taking ustekinumab should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
  58. Patients taking ustekinumab should not discontinue therapy to prevent SARS-CoV-2 infection.
  59. It is uncertain if patients taking ustekinumab should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.
  60. Patients taking ustekinumab should stop therapy if they develop COVID-19.
  61. It is uncertain if tofacitinib increases the risk of infection with SARS-CoV-2.
  62. It is uncertain if tofacitinib increases the risk of COVID-19.
  63. Patients taking tofacitinib should not reduce the dose of therapy to prevent SARS-CoV-2 infection.
  64. Patients taking tofacitinib should not discontinue therapy to prevent SARS-CoV-2 infection.
  65. Patients taking tofacitinib should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.\*
  66. Patients taking tofacitinib should stop therapy if they develop COVID-19.
  67. It is uncertain if patients taking combination therapy with an anti-TNF and thiopurine/methotrexate should reduce the dose of the thiopurine/methotrexate to prevent infection from SARS-CoV-2.
  68. Patients taking combination therapy with an anti-TNF and thiopurine/methotrexate should stop the thiopurine/methotrexate if they test positive for SARS-CoV-2 but don't have COVID-19.
  69. Patients taking combination therapy with an anti-TNF and thiopurine/methotrexate should stop the thiopurine/methotrexate if they develop COVID-19.
  70. Patients taking clinical trial drugs should not discontinue therapy to prevent SARS-CoV-2 infection.
  71. Patients taking clinical trial drugs should stop therapy if they test positive for SARS-CoV-2 but don't have COVID-19.\*
  72. Patients taking clinical trial drugs should stop therapy if they develop COVID-19.
  73. A patient with moderately to severely active Crohn's disease or ulcerative colitis (new diagnosis or relapsing disease) should be treated with the same therapies you would choose in the pre-COVID-19 era.\*
  74. In an IBD patient who tests positive for SARS-CoV-2 and whose IBD meds have been stopped because of this, IBD meds can be restarted after 14 days (provided they have not developed COVID-19).
  75. In an IBD patient who develops COVID-19 and whose IBD meds have been stopped, IBD meds can be restarted after COVID-19 symptoms resolve.\*
  76. In an IBD patient who develops COVID-19 and whose IBD meds have been stopped, IBD meds can be restarted after 2 nasopharyngeal PCR tests are negative.

\* *These are statements that had a higher degree of disagreement amongst the panellists.*

Appendix: What medications are discussed here? This table is for reference to explain the different treatments mentioned in the summary.

<b>THERAPY TYPE</b>	<b>ALSO KNOWN AS</b>
5-ASA	Asacol, Apriso, balsalazide, Dezicol, Lialda, mesalamine, mesalazine, Pentasa
Budesonide (steroid with limited systemic effects)	Entocort, Uceris
Steroids (the dose discussed is oral prednisone and $\geq 20$ mg per day)	Prednisone, Medrol, Hydrocortisone
Thiopurines	6-mercaptopurine, azathioprine, Azasan, Purinethol
Methotrexate	Trexal, Rheumatrex
JAK inhibitor	tofacitinib (Xeljanz)
Anti-TNF	adalimumab (Humira, Abrilada, Ajevita, Cyltezo, Hyrimoz, Hadlima), certolizumab pegol (Cimzia), golimumab (Simponi), infliximab (Remicade, Avsola, Inflectra, Ixifi Remsima, Renflexis)
Anti-IL12/23	ustekinumab (Stelara)
Anti-integrin	vedolizumab (Entyvio), natalizumab (Tysabri)
Calcineurin inhibitors (not discussed here)	cyclosporine (Gengraf, Neoral, Sandimmune), tacrolimus (Prograf, FK506)
Enteral nutrition (not discussed here)	