Supplementary Figure 1: Recommended regimens for pharmacologic VTE prophylaxis in COVID-19 infection

D-Dimer	Weight	CrCl ≥ 30 ml/min	CrCl < 30 mL/min OR on dialysis
<1000	<100kg	Enoxaparin 40mg SQ Daily	Heparin 5000 units SQ q8 hours
	100-150kg	Enoxaparin 40mg SQ Q12 hours	Heparin 7500 units SQ q8 hours
	>150kg	Enoxaparin 60mg SQ Q12 hours	Heparin 7,500 units SQ q8 hours
1000->3000	<100kg	Enoxaparin 40mg SQ Q12 hours	Heparin 7,500 units SQ q8 hours
	100-140kg	Enoxaparin 60mg SQ Q12 hours	Heparin 10,000 units SQ q8 hours
	141-180kg	Enoxaparin 80mg SQ Q12 hours	Heparin 10,000 units SQ q8 hours
	181-220kg	Enoxaparin 100mg Q12 hours	Heparin 10,000 units SQ q8 hours
	221-280kg	Enoxaparin 120mg Q12 hours	Heparin thrombotic nomogram
	>281kg	Enoxaparin 150mg Q12 hours	Heparin thrombotic nomogram
>3000 High clinical suspicion for thrombosis	<150kg	Enoxaparin 1mg/kg SQ q12 hours	Heparin thrombotic nomogram
>3000 High clinical suspicion for thrombosis	>150kg	Heparin thrombotic nomogram	Heparin thrombotic nomogram

Listed above is our institutional policy for pharmacological VTE prophylaxis in patients with COVID-19 infection.

We dosed the anticoagulation based on the D-Dimer level and patient's weight.

- Patient's with D-Dimer <1000 received **standard weight based** VTE prophylaxis
- Patient's with D-Dimer 1000-3000 received the **intermediate-dose of weight based** VTE prophylaxis
- Patient's with D-Dimer > 3000 and high suspicion for thrombosis received **full dose** anticoagulation

Supplementary Figure 2: Guidance for considering Remdesevir in patients with COVID-19 infection:

To qualify for Remdesevir, patients needed to meet following Criteria:

- Adults > 18 years of age with positive RT-PCR for COVID-19
- Mechanical Ventilation
- Adequate Kidney function (GFR > 30)
- Adequate Liver function (AST and ALT < 5 times upper limit of normal)
- Not on any vasopressors
- Not in multiorgan failure
- Not pregnant

Supplementary Figure 3: Guidance for using Tocilizumab

Consider Tocilizumab in patients with evidence of Cytokine Storm Syndrome

Evidence of cytokine storm syndrome - If 5 of the 7

1) Persistent fever, culture-neg
2) hepatomegaly or splenomegaly,
3) cytopenia (bi-cytopenia or pancytopenia)
4) AST> 30 IU/L.
5) triglyceride >132 mg/dL,
6) fibrinogen<250 mg/dL,
7) ferritin>2,000 ng/ml

Dx: COVID-19 Cytokine Release Syndrome (CRS) or Cytokine Storm Syndrome (CSS) when:

- 5 out of 7 + above, OR

- Significant O2 requirement (>40% FiO2) with <5 out of 7, OR

- Hypotension starting pressor support with <5 out of 7, OR

- Clinically worsening with AKI or encephalopathy with <5 out of 7

TOCILIZUMAB NOT RECOMMENDED IN-

1. Known active infections
2. chronic or recurrent infections
3. who have been exposed to tuberculosis
4. with a history of serious or an opportunistic infection
5. who have resided or traveled in areas of endemic tuberculosis or endemic mycoses; or
6. with underlying conditions that may predispose them to infection
7. Hypersensitivity reactions
8. ALT / AST> 5 times the upper limit of the normality
9. Absolute neutrophil count (ANC) less than 500 per mm3. Not recommended in ANC<2000 per mm3
10. Platelets <50.000 / mmc. Non recommended in platelets <100,000/mmc
11. Bowel diverticulitis or perforation

Supplementary Figure 4: Ideal PEEP determination:

Most of our patients were managed by low tidal volume lung protective ventilation.

Ideal PEEP was determined by:

- Target PaO_2 of 55-70 mmHg
- Plateau pressure of < 30 cm H_2O
- Driving pressure of < 15 cm H_2O