Why Are Hospitals Still Using Remdesivir?

May 30, 2023 • by Stella Paul

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Nobody believes in Remdesivir anymore. How can you possibly make a case for it? Remdesivir is so lethal it got nicknamed "Run Death Is Near" after it started killing thousands of Covid patients in the hospital. The experts claimed that Remdesivir would stop Covid; instead, it stopped kidney function, then blasted the liver and other organs.

As word got around, some patients started showing up in the emergency room with signs saying, "NO REMDESIVIR" and refusing to take it. (Not that their refusal helped: many were given it anyway, often without their knowledge.)

When I heard that Remdesivir is still being used, I couldn't believe it. How could hospitals be so brazen as to push this killer drug, even after the lawsuits (https://www.cbsnews.com/losangeles/news/widows-suing-inland-empire-hospitals-for-covid-19-treatments-involving-remdesivir/) started flying? Fourteen California families are now suing (https://ehlinelaw.com/blog/3-california-hospitals-face-lawsuits-f) three hospitals, claiming their loved ones suffered wrongful deaths from what they call "the Remdesivir protocol." Expect other lawsuits to follow, because the Remdesivir carnage was nationwide.

I began to poke around to see if hospitals are still giving Remdesivir and I think I've found the smoking gun. Two smoking guns, in fact. First, it's *still* listed on the NIH web site as its standard of care for Covid. Second (and in my opinion, more importantly), the CMS.gov official website (https://www.cms.gov/medicare/covid-19/new-covid-19-treatments-add-payment-nctap)

says, “The COVID-19 public health emergency (PCE) ended at the end of the day on May 11, 2023.” Two sentences later, it states, “The enhanced payments described on this page will end on September 30, 2023.” And there it is, listed in bold: Remdesivir.

Table 2b. Therapeutic Management of Hospitalized Adults With COVID-19

Last Updated: April 20, 2023

Disease Severity	Recommendations for Antiviral or Immunomodulator Therapy		Recommendations for Anticoagulant Therapy
	Clinical Scenario	Recommendation	
Hospitalized for Reasons Other Than COVID-19	Patients with mild to moderate COVID-19 who are at high risk of progressing to severe COVID-19[a,b]	See Therapeutic Management of Nonhospitalized Adults With COVID-19.	For patients without an indication for therapeutic anticoagulation: • **Prophylactic dose of heparin**, unless contraindicated **(AI)**; **(BIII)** for pregnant patients
Hospitalized but Does Not Require Oxygen Supplementation	All patients	The Panel **recommends against** the use of **dexamethasone (AIIa)** or other systemic corticosteroids **(AIII)** for the treatment of COVID-19.[c]	
	Patients who are at high risk of progressing to severe COVID-19[a,b]	**Remdesivir[d] (BIII)**	
Hospitalized and Requires Conventional Oxygen[e]	Patients who require minimal conventional oxygen	**Remdesivir[d,f] (BIIa)**	For nonpregnant patients with D-dimer levels above the ULN who do not have an increased bleeding risk: • **Therapeutic dose of heparin[h] (CIIa)** For other patients: • **Prophylactic dose of heparin**, unless contraindicated **(AI)**; **(BIII)** for pregnant patients
	Most patients	Use **dexamethasone plus remdesivir[f] (BIIa)**. If remdesivir cannot be obtained, use **dexamethasone (BI)**.	
	Patients who are receiving dexamethasone and who have rapidly increasing oxygen needs and systemic inflammation	Add **PO baricitinib[g] (BIIa)** or **IV tocilizumab[g] (BIIa)** to 1 of the options above.	

New COVID-19 Treatments Add-On Payment (NCTAP)

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023.
View Infectious diseases for a list of waivers and flexibilities that were in place during the PHE.

Review this page for information about Medicare payment during and after the PHE. **The enhanced payments described on this page will end on September 30, 2023.**

CMS issued an Interim Final Rule with Comment Period that established the New COVID-19 Treatments Add-on Payment (NCTAP) under the Medicare Inpatient Prospective Payment System (IPPS). The NCTAP, designed to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments, is effective from November 2, 2020, until September 30, 2023.

Through the NCTAP, Medicare will provide an enhanced payment through September 30, 2023, for eligible inpatient cases that use certain new products with current FDA approval or emergency use authorization (EUA) to treat COVID-19, including the following:

- **Convalescent plasma:** On August 23, 2020, the FDA issued (reissued on November 30, 2020, and revised on March 9, 2021) an EUA for the use of COVID-19 convalescent plasma for treating COVID-19 in hospitalized patients.
- **VEKLURY® (remdesivir):** On January 21, 2022, the FDA approved a supplemental New Drug Application (NDA) for VEKLURY, which expanded its use from adults and pediatric patients (12 years of age and older and weighing at least 40 kg) for the treatment of COVID-19 requiring hospitalization to certain non-hospitalized adults and pediatric patients for the treatment of mild-to-moderate COVID-19 disease. See the Federal Register announcement for more information about the revoked EUA and NDA approval.

Allow me to translate the bureaucratese. "Even though we acknowledge the Covid emergency is over, the federal government will continue to pay lavish bonuses to hospitals who kill their patients with Remdesivir through the end of the fiscal year."

Money; it all comes down to money. There's SO much money in the Covid con game. The CARES Act of 2020 slathered $2 trillion across the country to deal with Covid, and lots of it went to hospitals. The 20 largest hospitals enjoyed a 62 percent (https://www.openthebooks.com/substack-top-us-non-profit-hospitals--ceos-racked-up-huge-pandemic-profits/) increase in their combined net assets during those glorious Covid years, providing many top executives with a $10 million salary or more.

Alas, the federal government insisted (https://childrenshealthdefense.org/defender/billions-covid-stimulus-hospitals-treatments-killed-patients/) that if hospitals wanted to get paid, they had to treat Covid patients with Remdesivir. The fact that this drug was made by their good friends (https://www.opensecrets.org/orgs/gilead-sciences/summary?id=D000026221) at Gilead Science and everybody was getting rich (https://newsroom.vizientinc.com/en-US/releases/vizient-pharmacy-market-outlook-increased-use-remdesivir-for-covid-pushes-it-to-top-spot-in-total-vizient-member-spend) from the deals they cut had absolutely nothing to do with it, of course. It was all done for love of the people. But just to make sure that Remdesivir could attain its current billion-dollar status, the feds incentivized hospitals with a 20 percent boost (https://aapsonline.org/bidens-bounty-on-your-life-hospitals-incentive-payments-for-covid-19/) to the entire hospital bill of patients treated with Remdesivir.

And here's the kicker: the feds did not allow hospitals to even consider using safe, cheap drugs like ivermectin.

"Remdesivir caused a lot of renal failures," Ralph Lorigo told me. Mr. Lorigo is a lawyer in Buffalo who spent last year helping families rescue loved ones who

were trapped inside hospitals that were killing them. “If you got Covid, the hospital put you on this government protocol and didn’t even check if you have kidney disease. There was a real lack of monitoring.”

“I was surprised when the FDA approved it, even though The World Health Organization (WHO) had advised against (https://www.nbcnews.com/health/health-news/remdesivir-shouldn-t-be-used-hospitalized-covid-19-patients-who-n1248320) using it. But Big Pharma had the strength to push it through.”

He added, “Hospitals had stopped doing elective cases, which is how they made money. So now they made money giving people Remdesivir and putting them on ventilators, which the government also paid big bonuses for. Every day you’re on a vent, it’s damaging you. When I managed to get people out of the hospital and off the vent and they got ivermectin, they lived. When I couldn’t get into court or lost the case, they died.”

It’s way past time for there to be a hard stop on the use of Remdesivir. And we must work fast to save the children. “In late April 2022, the FDA even approved remdesivir as the first and only COVID-19 treatment for children under 12, including babies as young as 28 days, an approval that boggles the mind, considering COVID-19 is rarely serious in children while remdesivir is ineffective and carries a risk of serious, and deadly, side effect,” writes (https://childrenshealthdefense.org/defender/lawsuits-remdesivir-covid-cola/) Dr. Joseph Mercola.

In all my reporting on the Hospital Death Protocol, I’ve never heard a single person say, “You’re wrong. My mother perked right up when they gave her Remdesivir and the ventilation made her bounce out of bed. They saved her life!”

Instead, my inbox and Twitter feed are filled with messages that would make you break down and cry. The Bereaved Army in America needs an investigation into exactly who shattered their lives and why.

-End-

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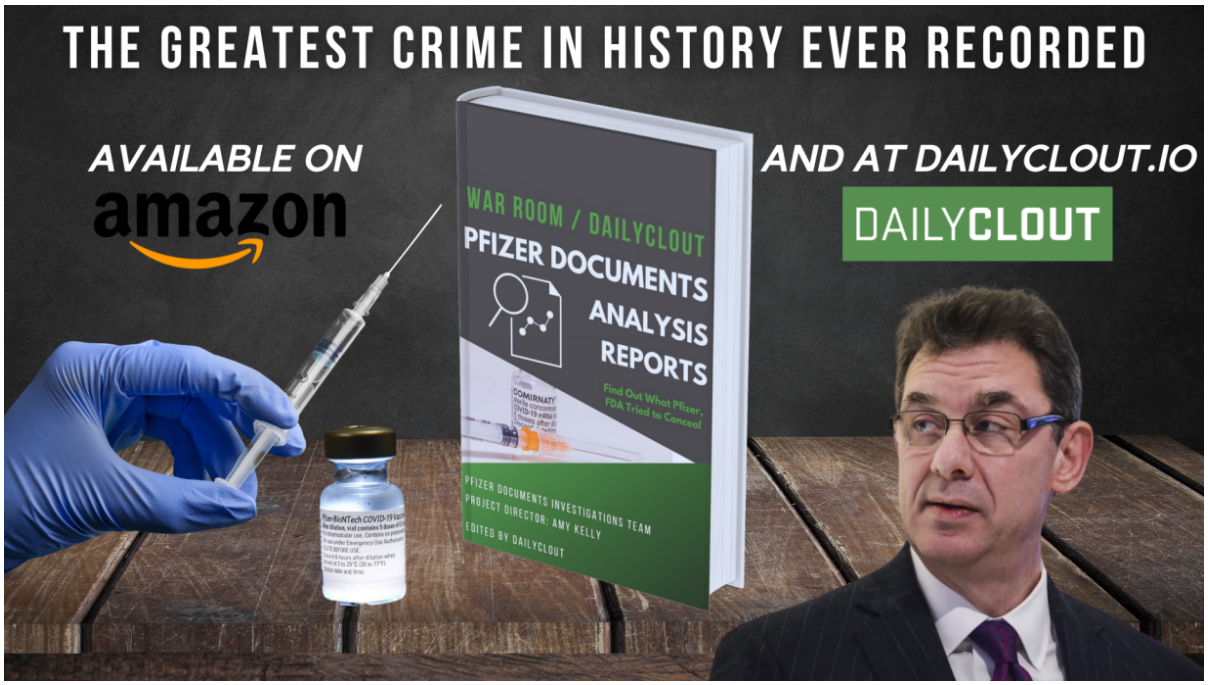

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Stella Paul is the pen name of a writer in New York who has covered medical issues for over a decade. In 2021, she lost her husband in a locked down nursing home in New York City where he had been brutally isolated for almost a year. He died one week after getting the vaccine. Stella is focused on exposing the Hospital Death Protocol to honor her husband's memory and to support thousands of bereaved families.

https://brownstone.org/author/stella-paul/ (https://brownstone.org/author/stella-paul/)

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kathy krech

May 31, 2023 Reply

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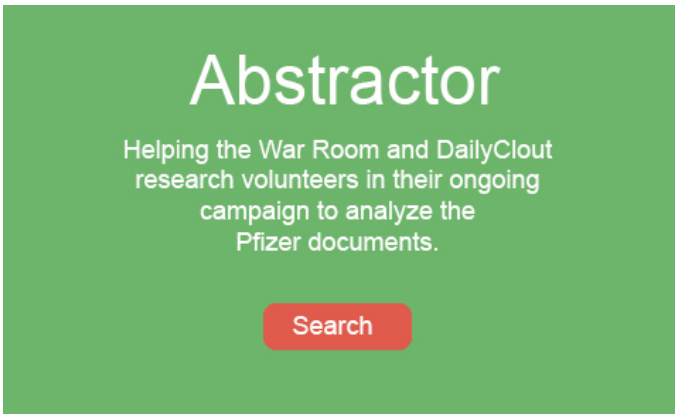

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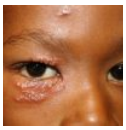

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