Unfortunately, going to the hospital today and being diagnosed with Covid-19 often guarantees a one-way trip to EUA treatment, isolation, ventilation, and higher probability of death than the disease itself. Dr. Fauci's NIH protocols often include an elixir of lung sedatives such as Midazolam (commonly used in lethal injections), experimental Remdesivir (which is known to damage kidneys) and the Ventilator. And additional treatment is also being put on an ECMO machine, more commonly known as an iron lung.

# IF HOSPITALIZED

**If you are hospitalized** and don't have an AD (Advanced Directive) already pre-loaded in your medical chart or are asked to sign a "consent for treatment" form, have that consent form printed out, **DO NOT SIGN the general electronic version**. On the printed version, you can customize its contents, crossing out and adding declarations as needed such as those noted above (NO VENTILATORS, NO REMDESIVIR, etc.) Then sign and date the updated form and return to the hospital.

Some Relevant Remdesivir Studies:

**Rapid review of suspected adverse drug events due to Remdesivir in the WHO database; findings and implications:** https://pubmed.ncbi.nlm.nih.gov/33252992/

**Conclusions :** Deterioration of liver and kidney function are frequently observed ADEs (Adverse Drug Events) with Remdesivir; consequently, patients should be monitored for these ADEs.

**Remdesivir and Acute Renal Failure: A Potential Safety Signal From Disproportionality Analysis of the WHO Safety Database:** https://pubmed.ncbi.nlm.nih.gov/33340409/

" ...we detected a statistically significant pharmacovigilance signal of nephrotoxicity associated with Remdesivir, deserving a thorough qualitative assessment of all available data."

**Why Remdesivir Failed: Preclinical Assumptions Overestimate the Clinical Efficacy of Remdesivir for COVID-19 and Ebola:** https://journals.asm.org/doi/epdf/10.1128/AAC.01117-21

"Here, we critically evaluate the assumptions of the models underlying Remdesivir's promising preclinical data and show that such assumptions over-predict efficacy and minimize toxicity of Remdesivir in humans."

**Association of Remdesivir Treatment With Survival and Length of Hospital Stay Among US Veterans Hospitalized With COVID-19:** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8283561/

"In this cohort study of 2344 US veterans hospitalized with COVID-19, Remdesivir therapy was not associated with improved 30-day survival but was associated with a significant increase in median time to hospital discharge.

The findings suggest that routine use of Remdesivir may be associated with increased use of hospital beds but not with improvements in survival."

**Remdesivir of scant benefit in hospitalized COVID patients, study finds:**
https://www.cidrap.umn.edu/news-perspective/2020/08/remdesivir-scant-benefit-hospitalized-covid-patients-study-finds

"The antiviral drug Remdesivir had little effect in patients with moderate COVID-19 in 105 hospitals in the United States, Europe, and Asia in a randomized, controlled, open-label trial published late last week in JAMA, adding to a mixed picture of the drug in randomized clinical trials (RCTs), which are considered the gold standard for gauging interventions."

## Medical Advocacy 101:

Once hospitalized, it is vital that your *Medical Freedom Army* activate and start doing everything in their power to get you out of the hospital. Once a safe transfer and care can be guaranteed, the patient should arrange discharge from the hospital. Depending on the patient's status, an ***Against Medical Advice*** form may need to be completed to relieve the hospital of any liability. Each hospital will likely offer particular services to patients, and it is every patient's right to be made aware of these advocacy services such as social workers, ethics committees and hospital designated patient advocates. The following attachment provides a helpful guide for navigating and communicating with the hospital and the patient's associated care team.

<<Medical Advocacy.pdf>>

## EFFECTIVE HOSPITAL TREATMENT PROTOCOLS FOR COVID-19

Examples of Treatments to Advocate for are Listed Below. Copies of these protocols should be given to your hospital providers AND all relevant parties and committees associated with the patient's care (i.e., hospital ethics committees, protocol committees, patient advocates, social workers, etc.)

Make sure that these boards and committees are also being held accountable for neglecting these well-founded, safe, and effective treatments.

**FLCCC Hospital Treatment Protocol (MATH+):**
https://covid19criticalcare.com/covid-19-protocols/math-plus-protocol/

# MATH+ HOSPITAL TREATMENT PROTOCOL FOR COVID-19

Version **13**
2021-06-30

| MEDICATION | INDICATION/INITIATION | RECOMMENDED DOSING | TITRATION/DURATION |
|---|---|---|---|
| **METHYLPREDNISOLONE** | A. *Upon oxygen requirement or abnormal chest X-ray* | Preferred: 80 mg IV bolus, then 40 mg IV twice daily<br>Alternate: 80 mg/240 ml normal saline IV infusion at 10 ml/hr<br>Follow COVID-19 Respiratory Failure protocol (see flccc.net/respiratory-support-c19/) | A1. If no improvement in oxygenation in 2–4 days, double dose to 160 mg/daily.<br>A2. Upon need for $FIO_2$ > 0.6 or ICU, escalate to "Pulse Dose" below (B)<br>A3. Once off IMV, NPPV, or High flow $O_2$, decrease to 20 mg twice daily. Once off $O_2$, then taper with 20 mg/day × 5 days then 10 mg/day × 5 days |
| | B. *Refractory Illness/ Cytokine Storm* | "Pulse" dose with 125 –250 mg IV every 6 hours | Continue × 3 days then decrease to 160 mg IV/ daily dose above, taper according to oxygen requirement (A). If no response or CRP/Ferritin high/rising, consider mega-dose IV ascorbic acid and/or "Therapeutic Plasma Exchange" below |
| **ASCORBIC ACID** | *$O_2$ < 4 L on hospital ward* | 500–1000 mg oral every 6 hours | Until discharge |
| | *$O_2$ > 4 L or in ICU* | 50 mg/kg IV every 6 hours | Up to 7 days or until discharge from ICU, then switch to oral dose above |
| | *If in ICU and not improving* | Consider mega-doses: 25 grams IV twice daily for 3 days | Completion of 3 days of therapy |
| **THIAMINE** | *ICU patients* | 200 mg IV twice daily | Up to 7 days or until discharge from ICU |
| **HEPARIN** (LMWH) | *If initiated on a hospital ward* | 1 mg/kg twice daily — Monitor anti-Xa levels, target 0.6–1.1 IU/ml | Until discharge then start DOAC at half dose × 4 weeks |
| | *If initiated in the ICU* | 0.5 mg/kg twice daily — Monitor anti-Xa levels, target 0.2–0.5 IU/ml | |
| **IVERMECTIN** * *(a core medication)* | *Upon admission to hospital and/or ICU* | 0.4–0.6 mg/kg per dose — daily (Take with or after meals) | For 5 days or until recovered |
| **Fluvoxamine** ** | *Hospitalized patients* | 50 mg PO twice daily | 10–14 days |
| **Cyproheptadine** | *If any of: 1) on fluvoxamine, 2) hypoxemic, 3) tachypneic/respiratory distress, 4) oliguric/kidney injury* | 8 mg — 3 x daily | until discharge, slow taper once sustained improvements noted |
| **Anti-Androgen Therapy** | *Hospitalized patients (Men only)* | Dutasteride 0.5 mg daily or Finasteride 5 mg daily | until fully recovered |
| **Vitamin D** | *Hospitalized patients* | Calcifediol preferred: 0.5 mg PO day 1, then 0.2 mg PO day 2 and weekly thereafter<br>Cholecalciferol: 20,000–60,000 IU single dose PO then 20,000 IU weekly | Until discharge |
| **Atorvastatin** | *ICU Patients* | 80 mg PO daily | Until discharge |
| **Melatonin** | *Hospitalized patients* | 6–12 mg PO at night | Until discharge |
| **Zinc** | *Hospitalized patients* | 75–100 mg PO daily | Until discharge |
| **Famotidine** | *Hospitalized Patients* | 40–80 mg PO twice daily | Until discharge |
| **Therapeutic Plasma Exchange** | *Patients refractory to pulse dose steroids* | 5 sessions, every other day | Completion of 5 exchanges |

**Legend:** CRP = C-Reactive Protein, DOAC = direct oral anti-coagulant, $FIO_2$ = Fraction of inspired oxygen, ICU = Intensive Care Unit, IMV = Invasive Mechanical Ventilation, IU = International units, IV = Intravenous, NIPPV = Non-Invasive Positive Pressure Ventilation, $O_2$ = oxygen, PO (per os) = oral administration

* The safety of Ivermectin in pregnancy has not been established thus treatment decisions require an assessment of the risks vs. benefits in a given clinical situation.

** Some individuals who are prescribed fluvoxamine experience acute anxiety which needs to be carefully monitored for and treated by the prescribing clinician to prevent rare escalation to suicidal or violent behavior.

For **optional medicines** and an overview of the developments in prevention and treatment of COVID-19, please visit flccc.net/optional-medicines

*Please check our homepage www.flccc.net regularly for updates of our COVID-19 Protocols! – New medications may be added and/or dose changes to existing medications may be made as further scientific studies emerge!*

# MATH+ HOSPITAL TREATMENT PROTOCOL FOR COVID-19

Version 13
2021-06-30

## TO CONTROL INFLAMMATION & EXCESS CLOTTING

In all COVID-19 hospitalized patients, the therapeutic focus must be placed on early intervention utilizing powerful, evidence-based therapies to counteract:

— The overwhelming and damaging inflammatory response
— The systemic and severe hyper-coagulable state causing organ damage

By initiating the protocol soon after a patient meets criteria for oxygen supplementation, the need for mechanical ventilators and ICU beds will decrease dramatically.

## TREATMENT OF LOW OXYGEN

— If patient has low oxygen saturation on nasal cannula, initiate heated high flow nasal cannula.
— Do not hesitate to increase flow limits as needed.
— Avoid early intubation that is based solely on oxygen requirements. Allow "permissive hypoxemia" as tolerated.
— Intubate only if patient demonstrates excessive work of breathing.
— Utilize "prone positioning" to help improve oxygen saturation.

## ABOUT THE MATH+ HOSPITAL TREATMENT PROTOCOL FOR COVID-19

Our **MATH+** protocol is designed for hospitalized patients, to counter the body's overwhelming inflammatory response to the SARS-CoV-2 virus. The protocol is based on numerous medical journal publications over decades. It is the hyper-inflammation, not the virus itself, that damages the lungs and other organs and ultimately causes death in COVID-19. We have found the **MATH+** protocol to be a highly effective combination therapy in controlling this extreme inflammatory response and we have now added ivermectin as a core component given the profound emerging efficacy data in hospitalized patients reviewed here (www.flccc.net/flccc-ivermectin-review-covid-19).

The steroid **M**ethylprednisolone is a key component, increasing numbers of studies (see https://flccc.net/medical-evidence) show its profound effectiveness in COVID-19, which is made more potent when administered intravenously with high doses of the antioxidant **A**scorbic acid given that the two medicines have multiple synergistic physiologic effects. **T**hiamine is given to optimize cellular oxygen utilization and energy consumption, protecting the heart, brain, and immune system. The anticoagulant **H**eparin is important for preventing and dissolving blood clots that appear with a very high frequency in patients not given blood thinners. The **+** sign indicates several important co-interventions that have strong physiologic rationale and an excellent safety profile. It also indicates that we plan to adapt the protocol as our insights and the published medical evidence evolve.

Timing is a critical factor in the successful treatment of COVID-19. Patients must go to the hospital as soon as they experience difficulty breathing or have a low oxygen level. The **MATH+** protocol then should be administered soon after a patient meets criteria for oxygen supplementation (within the first hours after arrival in the hospital), in order to achieve maximal efficacy as delayed therapy has led to complications such as the need for mechanical ventilation.

If administered early, this formula of FDA-approved, safe, inexpensive, and readily available drugs can eliminate the need for ICU beds and mechanical ventilators and return patients to health.

## DISCLAIMER



## CONTACT

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**Dr. Zelenko Covid-19 Treatment Protocol:**

https://vladimirzelenkomd.com/treatment-protocol/

| ZELENKO COVID19 PROTOCOL (moderate/high risk, > 45 yrs old) | | | |
|---|---|---|---|
| **Items in orange are available OTC, others are prescription** | | | |
| **Prophylaxis** | | | **Treatment** |
| 1000mg, daily | Vitamin C | same | 1000mg, 7 days |
| 5000IU 125mcg, daily | Vitamin D3 | double | 10000IU 250mcg, 7 days<br>OR<br>50000IU, 1-2 days |
| 25mg, daily | Elemental Zinc | double | 50mg, 7 days |
| **Zinc Ionophore** | | | |
| 500mg, daily | Quercetin | double | 500mg, 2x - 7 days |
| OR | | - | OR |
| 400mg, daily | Epigallocatechin-gallate (EGCG) | same | 400mg, 1x - 7 days |
| OR | | - | OR |
| 200mg, 5 days, 200-400mg weekly | Hydroxychloroquine (HCQ) | double | 200mg, 2x - 5-7 days |
| OR | | - | AND/OR |
| 0.2mg/kg, day 1 & 3, weekly | Ivermectin (IVM)* | double | 0.4-0.5mg/kg, 5-7 days |
| *Example: IVM dosage for 200lb person (90kg) - Prophylaxis 18mg, Treatment 36mg-45mg | | | |
| **Antibiotic** | | | |
| --- | Azithromycin (Z-PAK) | add | 500mg, 1x - 5 days |
| | | | OR |
| --- | Doxycycline | add | 100mg, 2x - 7 days |
| **Other Treatment Options** | | | |
| corticosteroid | Dexamethasone 6-12mg 1 time a day for 7 days or | | |
| corticosteroid | Prednisone 20mg twice a day for 7 days, taper as needed | | |
| corticosteroid | Budesonide 1mg/2cc solution via nebulizer twice a day for 7 days | | |
| blood thinners | Blood thinners (i.e. Lovenox, Eliquis, Xarelto, Pradaxa, Aspirin) | | |
| anti-inflammatory | Colchicine 0.6mg 2-3 times a day for 5-7 days | | |
| | Monoclonal antibodies | | |
| | Home IV fluids and oxygen | | |