NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
Mark T. Benton • Deputy Secretary for Health
Kelly Kimple • Acting Director, Division of Public Health

To: All North Carolina Clinicians
From: Emma Doran, MD, MPH, Medical Epidemiologist
Subject: 2024-2025 Respiratory Virus Season: **Treatment Update for NC Clinicians** (4 pages)
Date: September 25, 2024

This memo provides guidance and information to NC clinicians regarding treatment for acute viral respiratory infections during the 2024-2025 respiratory season. As guidance may change during the season, up to date information will be available at flu.nc.gov.

CLINICAL MANAGEMENT: If clinically indicated, decisions about starting antiviral treatment should be based on clinical and epidemiologic information and not be delayed while awaiting laboratory confirmation.

Influenza

- Antiviral treatment is recommended as soon as possible for any patient with suspected or confirmed influenza who:
  - Is hospitalized
  - Has severe, complicated, or progressive illness
  - Is at increased risk for influenza complications
- Certain patients are at increased risk for influenza-related complications. These include:
  - Children younger than 5 years of age, especially those under 2 years of age
  - Adults 65 years of age or older
  - Pregnant people and people up to 2 weeks after the end of pregnancy
  - Hispanics or Latinos, African Americans, and American Indian/Alaska Natives
  - Persons with certain medical conditions including: asthma; neurological and neurodevelopmental conditions; chronic lung diseases; heart diseases; blood disorders; endocrine disorders; kidney diseases; liver disorders; metabolic disorders; and weakened immune system due to disease (such as people living with HIV or AIDS, or some cancers such as leukemia), or medications (such as those receiving chemotherapy or radiation treatment for cancer, or persons with chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system)
  - People younger than 19 years of age who are receiving long-term aspirin therapy or salicylate-containing medications
  - People who are obese with a Body Mass Index (BMI) of 40 kg/m^2 or higher
  - People who live in nursing homes or other long-term care facilities
  - People who have had a stroke

- Treatment is most effective when started within 48 hours of illness onset. However, treatment of persons with prolonged or severe illness can reduce mortality and duration of hospitalization even when started more than 48 hours after illness onset.
    - Detailed guidance on antiviral use is available here.

Antiviral Treatment	Who	How
Oseltamivir (Tamiflu)	-Hospitalized patients any age -Outpatient adults and children any age with complications or progressive disease -Outpatient adults and children any age with acute uncomplicated influenza -Pregnant people	Orally for 5 days
Zanamivir (Relenza)	-Outpatient adults and children ages 7 years and older with acute uncomplicated influenza	Inhaled for 5 days
Peramivir (Rapivab)	-Outpatient adults and children ages 6 months and older with acute uncomplicated influenza	Intravenous (IV) for 1 day
Baloxavir (Xofluza)	-Outpatient adults and children ages 5 years and older who are otherwise healthy with acute uncomplicated influenza OR -Adults and children ages 12 years and older who are at high risk of developing complications	Orally for 1 day

- Chemoprophylactic use of antiviral medications is recommended to control flu outbreaks among high-risk persons in institutional settings (e.g. congregate living facilities and health care facilities). For control of outbreaks in institutional settings, CDC recommends antiviral chemoprophylaxis of exposed residents with oral oseltamivir or inhaled zanamivir for a minimum of 2 weeks and continuing up to 1 week after the last known case was identified. Antiviral chemoprophylaxis is recommended for all residents, including those who have received influenza vaccination.
- Post-exposure chemoprophylaxis could also be considered for close contacts of cases (confirmed or suspected) who are at high risk for complications of influenza, including pregnant women, if antivirals can be started within 48 hours of the most recent exposure. Recommended duration is 7 days (after last known exposure).
    - More information on influenza chemoprophylaxis can be found here.

Antiviral Prophylaxis	Who	How
Oseltamivir (Tamiflu)	Adults and children ages 3 months and older*	Orally for 7 days
Zanamivir (Relenza)	Adults and children ages 5 years and older	Inhaled for 7 days
Baloxavir (Xofluza)	Adults and children ages 5 years and older	Orally for 1 day

*For infants younger than 3 months old, use of oseltamivir for chemoprophylaxis is not recommended unless the situation is judged to be critical due to limited data in this age group

COVID-19

- Antiviral treatment of outpatients at risk of severe COVID-19 reduces their risk of hospitalization and death. Risk factors for severe COVID-19 include:
    - Age over 50 years, with risk increasing substantially at age ≥ 65 years

- Being unvaccinated or not being up to date on COVID-19 vaccinations
- Specific medical conditions and behaviors with conclusive high risk including asthma, cancer, cerebrovascular disease, chronic kidney, lung and liver diseases, cystic fibrosis, dementia, diabetes mellitus, disabilities including Down syndrome, heart failure, coronary artery disease, cardiomyopathies, HIV or AIDS, mood disorders, neurologic conditions including dementia, obesity, physical inactivity, pregnancy and recent pregnancy, primary immunodeficiencies, smoking (current and former), solid organ or blood stem cell transplantation, tuberculosis and use of corticosteroids or other immunosuppressive medications
- Some racial and ethnic minority groups are at risk of being disproportionately affected by COVID-19 because of many factors, including limited access to vaccines and healthcare.

- There are several FDA-authorized or approved antiviral medications that are commercially available to treat mild to moderate COVID-19 in people who are at high risk of complications.
  - Detailed clinical considerations for COVD-19 treatment in outpatients can be found here.

Antiviral Treatment	**Who (Among people at high risk of complications)**	**When**	**How**	**Patient Assistance Available**
Nirmatrelvir with Ritonavir (Paxlovid)*	Adults and children ages 12 years and older	Start as soon as possible; must begin within 5 days of when symptoms start	Orally for 5 days	To ensure patients pay as little as $0 for Paxlovid, regardless of insurance status, prescribers can enroll their patients in PAXCESS by going to paxlovid.iassist.com or by calling 1-877-C19-PACK
Remdesivir (Veklury)	Adults and children aged 28 days and older and at least 3kg	Start as soon as possible; must begin within 7 days of when symptoms start	Intravenous (IV) for 3 days	Patient support is available at Gilead's Advancing Access
Recommended to use if above medications cannot be used or unavailable.				
Molnupiravir (Lagevrio)	Adults only	Start as soon as possible; must begin within 5 days of when symptoms start	Orally for 5 days	The Merck Patient Assistance Program offers free Lagevrio to eligible patients. Visit MerckHelps.com/LAGEVRIO or call 1-800-727-5400

*Clinicians should be aware of Paxlovid interactions and contraindications. FDA has created a eligibility screening checklist tool for prescribers.

- Pre-exposure prophylaxis medication is available for people who are moderately or severely immunocompromised and unlikely to mount an adequate immune response to COVID-19 vaccination for additional protection against COVID-19.
    - Pre-exposure prophylaxis helps prevent COVID-19 but does not take the place of vaccination in people who are eligible to receive an updated COVID-19 vaccine.
    - More information about pre-exposure prophylaxis can be found here.

Pre-Exposure Prophylaxis	Who	When	How
Pemivibart (Pemgarda)	Adults and children 12 years and older who have moderate-to-severe immune compromise	Administer at least 2 weeks after receiving a dose of COVID-19 vaccination	Intravenous (IV) administered as a single infusion once every 3 months

- FDA has authorized or approved the use of several medications for hospitalized patients with severe or critical illness due to COVID-19. Clinicians can find general considerations and recommendations for their care in the IDSA Guidelines on the Treatment and Management of Patients with COVID-19.

RSV and other respiratory viruses: There is no specific treatment available for RSV.

Patients should seek emergency medical attention for any of the following:

- Difficulty breathing or shortness of breath
- Persistent pain or pressure in the chest or abdomen
- Persistent dizziness or confusion
- Severe muscle pain, weakness or unsteadiness
- Not urinating
- Fever or cough that improve but then return or worsen
- Worsening of chronic medical conditions
- In children, fever above 104° F, bluish gray skin color, lack of responsiveness, extreme irritation, dehydration (no urine for 8 hours, dry mouth, no tears when crying), or ribs pulling in with each breath
- Any other symptom that is severe or concerning

Clinicians should contact their Local Health Departments or the Communicable Disease Branch epidemiologist on-call available 24/7 at (919) 733-3419 for questions about respiratory viral treatments.

cc: Dr. Erica Wilson, Medical Director, Medical Consultation Unit
Evelyn Foust, Branch Head, Communicable Disease Branch
Dr. Zack Moore, State Epidemiologist

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
Mark T. Benton • Deputy Secretary for Health
Kelly Kimple • Acting Director, Division of Public Health

To: All North Carolina Clinicians
From: Emma Doran, MD, MPH, Medical Epidemiologist
Subject: 2024-2025 Respiratory Virus Season: **Infection Prevention and Control for NC Clinicians** (3 pages)
Date: September 25, 2024

This memo provides information and guidance to NC clinicians regarding infection control measures to prevent the spread of respiratory viral diseases. As guidance may change during the respiratory season, up to date information will be available at flu.nc.gov. Preventive measures to reduce the spread of influenza, RSV, COVID-19 and other respiratory viruses are critical because along with seasonal influenza and RSV viruses, SARS-CoV-2 virus is now part of the respiratory season. Increased activity of all three viruses at the same time could have a significant impact on the healthcare system.

INFECTION CONTROL IN HEALTHCARE SETTINGS

- Infection control strategies in healthcare facilities need to be multi-faceted as transmission of respiratory viruses can occur among patients, staff and visitors. Facilities should use a hierarchy of controls approach to prevent the exposure and transmission of respiratory viruses to healthcare personnel and patients within healthcare settings. Consistent infection control measures should be applied to ALL patients who present with acute febrile respiratory illness. Consult CDC's infection control guidance for Respiratory Viruses, COVID-19, and Influenza for additional details.
- Outpatient medical providers who are referring patients with suspected or confirmed respiratory virus infection to emergency departments or other medical facilities should call ahead to alert the facility that the patient is arriving and instruct the patient to wear a surgical mask before entering the clinical facility. The patient should also be instructed to inform healthcare personnel immediately upon arrival of any respiratory symptoms.
- All staff working in a healthcare setting, who do not have a medical contraindication, should be vaccinated annually against influenza and be up to date with COVID-19 vaccines. Staff members who feel ill should be instructed not to report to work but instead remain at home.

GENERAL CONTROL MEASURES

Stay up to date with vaccinations

Vaccine	Who	What	Notes
Influenza	Everyone 6 months of age and older[1]	Annual flu vaccine	

[1] Seasonal influenza vaccination is especially important for people who are at high risk of developing serious complications such as pneumonia if they get sick with the flu, and people who live with or care for others who are at high risk of developing complications.

COVID-19	Everyone 6 months of age and older[2]	Updated 2024-2025 COVID-19 vaccine	
RSV	Adults 75 years and older; Adults 60-74 years old who are at increased risk of severe RSV	One-time, single dose of RSV vaccine	
	Previously unvaccinated pregnant persons during gestational weeks 32 through 36 of pregnancy OR -Infants from birth to 8 months old entering their first RSV season -Children 8-19 months old at high risk of severe RSV entering their second RSV season[3]	One dose of bivalent, maternal RSV vaccine (ABRYSVO) to prevent severe RSV in infants OR -One dose of nirsevimab (Beyfortus) -Alternatively, a different monoclonal antibody, palivizumab (Synagis) is limited to children under 24 months old with certain conditions that place them at high risk of severe RSV[4]	• Please note that doses administered through the North Carolina Immunization Program (NCIP) are for Vaccines For Children eligible children only. Fully insured children must receive privately purchased Beyfortus. • Doses of ABRYSVO obtained through NCIP are available for VFC-eligible pregnant adolescents only. Fully insured, pregnant adolescents must receive privately purchased ABRYSVO. • For uninsured pregnant individuals ages 19 years and older, please reach out to Pfizer Patient Assistance Program

- Based on North Carolina's RSV surveillance data, which indicates a trend of an earlier start to the RSV season, the North Carolina Department of Health and Human Services (NCDHHS) is recommending administrations of RSV vaccines earlier than CDC's national recommendation.
    - Nirsevimab (Beyfortus) administration should begin on September 15, 2024.
    - Maternal RSV vaccine administration with ABRYSVO should begin on August 15, 2024.
- Encourage patients to visit vaccines.gov to find their nearest pharmacy OR check with their Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, and other providers to locate vaccines.

[2] Recommendations are based on age, time since last dose, and in some cases, first vaccine received. People who are moderately or severely immunocompromised have specific recommendations for COVID-19 vaccines. Up-to-date information is described here.
[3] Most infants will likely only need protection from either maternal RSV vaccine or infant immunization with RSV monoclonal antibodies (Beyfortus) but not both. However, if a baby is born less than two weeks after maternal vaccination, then Beyfortus is recommended.
[4] See American Academy of Pediatrics guidelines for palivizumab use.

- Influenza, COVID-19, and RSV vaccines may be co-administered. Co-administration of these vaccines might be especially important when the patient has risk factors for severe respiratory illness and there might not be an opportunity to vaccinate the patient with all their recommended vaccines in the near future.
- A pneumococcal vaccine should be administered to all patients for whom it is indicated, including children younger than 5 years old and adults 65 years or older.
- Confirm that all school age children are up to date on all required and recommended vaccines. More information on NC immunization schedules for children can be found here.

Take precautions to prevent the spread of illness

- All patients with confirmed or suspected acute viral respiratory infection should be instructed to stay home and away from others until: they are fever-free (<100°F [37.8°C]) *without* the use of a fever-reducing medication AND their symptoms are getting better BOTH for 24 hours. Then patients should take added precautions for the next five days. Added precautions may include masking, distancing, and/or testing. The CDC respiratory virus guidance is available here.
- If COVID-19 is suspected or confirmed in a healthcare worker, CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure should be followed.
- Household contacts should be instructed to monitor themselves closely for symptoms. If they develop illness, they should stay at home and follow the guidance on home respiratory isolation.
- Please use every opportunity to educate patients on the importance of good respiratory hygiene, hand washing, physical spacing, masks, and other basic protective measures regardless of their vaccination status.

Follow recommendations for administration of influenza chemoprophylaxis

Chemoprophylactic use of antiviral medications is recommended to control flu outbreaks among high-risk persons in institutional settings (e.g. congregate living facilities and health care facilities). Post-exposure chemoprophylaxis could also be considered for close contacts of cases (confirmed or suspected) who are at high risk for complications of influenza, including pregnant women, if antivirals can be started within 48 hours of the most recent exposure. CDC does not recommend widespread or routine use of antiviral medications for chemoprophylaxis to limit the potential emergence of antiviral resistant viruses. An emphasis on close monitoring and early initiation of antiviral treatment if fever and/or respiratory symptoms develop is an alternative to chemoprophylaxis after a suspected exposure for some persons. Detailed guidance regarding antiviral chemoprophylaxis is available here.

Clinicians should contact their Local Health Departments or the Communicable Disease Branch epidemiologist on-call available 24/7 at (919) 733-3419 for questions about infection control measures.

Additional Resources

CDC Provider Toolkit: Preparing Patients for the Fall and Winter Virus Season

cc: Dr. Erica Wilson, Medical Director, Medical Consultation Unit
Evelyn Foust, Branch Head, Communicable Disease Branch
Dr. Zack Moore, State Epidemiologist

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
Mark T. Benton • Deputy Secretary for Health
Kelly Kimple • Acting Director, Division of Public Health

To: All North Carolina Clinicians
From: Emma Doran, MD, MPH, Medical Epidemiologist
Subject: 2024-2025 Respiratory Virus Season: **Surveillance Update for NC Clinicians** (3 pages)
Date: September 25, 2024

This memo provides information and guidance to NC clinicians regarding viral respiratory surveillance activities in North Carolina during the 2024-2025 respiratory season. As guidance may change during the season, up to date information will be available at flu.nc.gov.

Seasonal Influenza

In North Carolina, all influenza-associated deaths (adult and pediatric) are reportable to the Local Health Department. Specimens from patients who die from influenza should also be sent to the State Laboratory of Public Health (SLPH) for further characterization. An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza (any strain) by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death. A death should *not* be reported if:

1) There is no laboratory or rapid test confirmation of influenza virus infection
2) The influenza illness is followed by full recovery to baseline health status prior to death, or
3) After review and consultation, there is an alternative agreed upon cause of death.

Please reach out to your Local Health Department or the Communicable Disease Branch epidemiologist on-call available 24/7 at (919) 733-3419 for questions about reporting influenza-associated deaths.

Human Novel or Variant Influenza

In addition to influenza deaths, **human novel or variant influenza virus cases are reportable in North Carolina.** NC DPH requests your assistance with enhanced influenza surveillance and testing of individuals presenting with compatible illness and relevant exposure including contact with livestock, poultry, sick or dead wild animals, or raw milk or dairy products within the 10 days before symptom onset. Please follow the algorithm on page 3 for detailed considerations when assessing influenza-like illness in patients. Additional information is available on the NC DHHS Avian Flu Website including the Provider Memo page.

Surveillance and Tracking

North Carolina Division of Public Health (NC DPH) conducts surveillance for influenza, RSV, COVID-19 and other respiratory viruses using several systems. Surveillance is conducted for all visits to emergency departments across the state for influenza-like, RSV-like, and COVID-like illnesses. Information on

weekly laboratory data is also gathered from the State Laboratory of Public Health and from public health epidemiologists (PHEs) at eight of the state's largest healthcare systems. More detailed data is available on the NC Respiratory Virus Surveillance Dashboard.

NC DPH conducts surveillance and laboratory testing of outpatients seen by clinicians through participation in the Influenza-Like Illness Network (ILINet). Thirty practices are participating in ILINet for the 2024-2025 season so far. Please consider joining ILINet if you have not done so.

NC DPH also conducts wastewater monitoring for COVID-19 and is adding influenza and RSV detection to the state wastewater monitoring program. The NC Wastewater Monitoring Dashboard displays a detailed summary of these metrics.

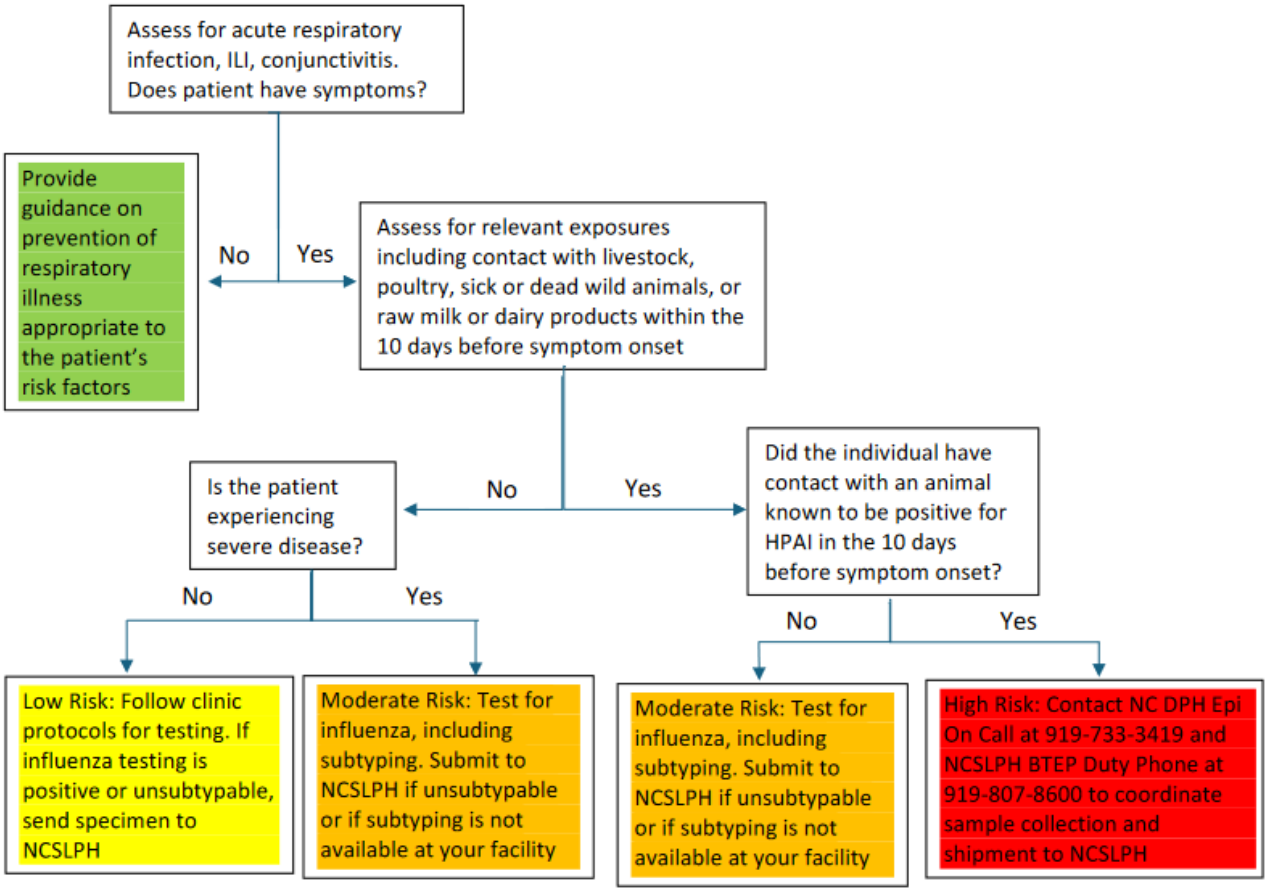
The testing and surveillance strategies used by NC DPH are consistent with recommendations from the CDC and make use of the strong viral respiratory surveillance systems currently in place in North Carolina. Additional CDC guidance and information on respiratory illnesses is available here.

Additionally, we ask you to please report **to your local health department all viral respiratory outbreaks**, particularly among young children in childcare and educational settings, and residents of long-term care facilities or other congregate living facilities. **We strongly recommend sending specimens collected from patients in influenza outbreaks to the State Laboratory of Public Health (SLPH) for further characterization.**

A weekly summary of NC respiratory surveillance data is available on the Respiratory Virus Surveillance Dashboard. Clinicians should contact their Local Health Departments or the Communicable Disease Branch epidemiologist on-call available 24/7 at (919) 733-3419 for questions about viral respiratory infections.

cc: Dr. Erica Wilson, Medical Director, Medical Consultation Unit
Evelyn Foust, Branch Head, Communicable Disease Branch
Dr. Zack Moore, State Epidemiologist

Testing Algorithm



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
Mark T. Benton • Deputy Secretary for Health
Kelly Kimple • Acting Director, Division of Public Health

To: All North Carolina Clinicians
From: Emma Doran, MD, MPH, Medical Epidemiologist
Subject: 2024-2025 Respiratory Virus Season: **Testing Update for NC Clinicians** (3 pages)
Date: September 25, 2024

This memo provides information and guidance to NC clinicians regarding testing for respiratory viruses in North Carolina during the 2024-2025 respiratory season. As guidance may change during the season, up to date information will be available at flu.nc.gov. Testing plays a critical role in detecting acute respiratory viral infections including infections with novel or variant influenza viruses that could have pandemic potential. Seasonal influenza, RSV, and COVID-19 may co-circulate throughout the respiratory season and co-infection with multiple viruses at the same time can occur.

Testing

Diagnostic tests available for detection of viruses in respiratory specimens include molecular assays (including rapid molecular assays, reverse transcription polymerase chain reaction (RT-PCR) and other nucleic acid amplification tests); and antigen detection tests (including rapid influenza diagnostic tests and immunofluorescence assays). Sensitivity and specificity can vary by the pathogen or test type, illness onset to specimen collection, the prevalence of viruses in patient population and other factors. Overall, molecular assays have a higher sensitivity and specificity than rapid antigen tests.

When available, multiplex assays for simultaneous detection of influenza, RSV and SARS-CoV-2 viruses should be used. It is possible for a patient to be infected with two or more viruses at the same time. Co-infections can impact the clinical management of acute respiratory illness. Testing for suspected pathogens should be considered particularly in hospitalized patients with severe respiratory disease. Additional guidance for clinicians when SARS-CoV-2 and influenza viruses are co-circulating can be found here.

A negative rapid antigen test does NOT rule out infection and should not be used for treatment or infection control decisions during periods when influenza, RSV, and/or SARS-CoV-2 viruses are known to be circulating.

- RSV: Antigen testing is sensitive in children but less sensitive in adults. Healthcare providers should use highly sensitive rRT-PCR assays when testing older children and adults for RSV.
- COVID-19: A negative viral test result does not rule out infection and should be repeated following CDC and FDA recommendations.
- Influenza: Providers should be aware of circulating influenza viruses. More information is available on the NC Respiratory Virus Surveillance Dashboard.

Influenza and COVID-19 testing is available at the North Carolina State Laboratory of Public Health (SLPH). Information on how to submit to SLPH can be found in SCOPE. Specimens should be submitted to SLPH for further testing and characterization in the following circumstances:

1. Specimens from confirmed influenza cases with severe illness and a poor prognosis.
2. Specimens from influenza associated deaths (adult and pediatric).
3. Patients who die with influenza-like illness but have no laboratory evidence of influenza, SARS-CoV-2, or other respiratory infection on a multiplex panel.
4. Patients who are critically ill with influenza-like illness but have no laboratory evidence of influenza, SARS-CoV-2, or other respiratory infection on a multiplex panel.
5. Patients with influenza-like illness, with or without confirmatory testing for influenza, who have had contact with livestock including domestic or wild swine (pigs) or poultry (birds), cattle, sick or dead wild animals, or raw milk or dairy products within the 10 days before symptom onset.
6. Influenza positive specimens that are unable to be subtyped by tests designed to provide an influenza subtyping result.
7. A sample of patients with influenza-like illness seen at facilities participating in the outpatient Influenza-Like Illness Network (ILINet) or Influenza Hospitalization Surveillance Program (IHSP/RESP-NET). Please consider joining ILINet if you have not done so.

Testing at the SLPH should also be considered for other patients in outbreaks in institutional settings or congregate living facilities and clusters of severe or unusual respiratory illness. Consult CDC testing and management considerations for residents of long-term care facilities with acute respiratory illness symptoms when SARS-CoV-2 and Influenza viruses are co-circulating as needed.

All specimens submitted to SLPH for influenza or SARS-CoV-2 testing will be tested for both influenza and SARS-CoV-2. Specific guidance regarding specimen collection and transport is available here.

Human Novel or Variant Influenza

NC DPH requests your assistance with enhanced influenza surveillance and testing of individuals presenting with compatible illness and relevant exposure including contact with livestock, poultry, sick or dead wild animals, or raw milk or dairy products within the 10 days before symptom onset. Please follow the algorithm on page 3 for detailed considerations when assessing influenza-like illness in patients. Additional information is available on the NC DHHS Avian Flu Website including the Provider Memo page.

Availability of Free At-home COVID Test Kits

Community-based organizations and other partners, who are making at-home COVID-19 test kits available to members of their community, can order at-home COVID-19 test kits directly from the federal government for free. Bulk orders can be placed via the Health Partner Order Portal (HPoP). Step-by-step guidance on how to register for an HPoP account and place orders, can be found here. Organizations must not sell or seek reimbursement for the test kits that the federal government provides at no cost.

All U.S. households will be eligible to order four free at-home COVID-19 tests at COVIDTests.gov at the end of September 2024. Patients can also find organizations providing free at-home COVID-19 test kits

in their community here. There are currently more than 260 active Community Access Points (CAPs), providing free at-home test kits across the state.

Clinicians should contact their Local Health Departments or the Communicable Disease Branch epidemiologist on call available 24/7 at (919) 733-3419 for questions about respiratory virus testing.

cc: Dr. Erica Wilson, Medical Director, Medical Consultation Unit
Evelyn Foust, Branch Head, Communicable Disease Branch
Dr. Zack Moore, State Epidemiologist

Testing Algorithm