Unfortunately, going to the hospital today and being diagnosed with Covid-19 often guarantees a one way trip to EUA treatment, isolation, ventilation and death. Dr. Fauci's NIH protocols often include an elixir of lung sedatives such as Midazolam (used in legal injections), experimental Remdesivir (which is known to damage kidneys) and the Ventilator.

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 in order 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

Examples of Treatments to Advocate for are Listed Below.

EFFECTIVE HOSPITAL TREATMENT PROTOCOLS FOR COVID-19

***Copies of these protocols should be given 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/

FLCCC ALLIANCE

FRONT LINE COVID-19 CRITICAL CARE ALLIANCE
PREVENTION & TREATMENT PROTOCOLS FOR COVID-19

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 Alternate: 80 mg/240 ml normal saline IV infusion at 10 ml/hr 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. A2. Upon need for FIO_2 > 0.6 or ICU, escalate to "Pulse Dose" below (B) 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 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!

flccc.net

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

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.

doses of the antioxidant Ascorbic acid given that the two medicines have multiple synergistic physiologic effects. Thiamine is given to optimize cellular oxygen utilization and energy consumption, protecting the heart, brain, and immune system. The

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

This protocol is solely for educational purposes regarding potentially beneficial therapies for COVID-19. Never disregard professional medical advice because of something you have read on our website and releases. It is not intended to be a substitute for professional medical advice, diagnosis, or treatment in regards to any patient. Treatment for an individual patient should rely on the judgement of your physician or other qualified health provider. Always seek their advice with any questions you may have regarding your health or medical condition.

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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!

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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 OR 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		