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Authors' response

We thank the author for a close reading of our article and for suggesting an alternate dosing regimen of HCQ for prophylaxis against SARS-CoV-2 infection[1]. Given that the dosing proposed by the author is higher than the current recommendation, we feel that it would be prudent to establish the safety as well as efficacy of the proposed regimen through clinical studies. There is evidence from physiology-based pharmacokinetic models, which suggest that even at lower doses HCQ can attain pulmonary concentrations at which it may exhibit anti-SARS-CoV-2 properties *in vitro*[2]. Other models, which define the distribution of CQ in human beings, have suggested that once weekly dosing regimen could help attain effective drug concentration in the lungs[3].

Further, single-dose kinetic studies of CQ used for malaria chemoprophylaxis indicate that adequate plasma concentrations are achieved after four weeks of use, before which the individual remains susceptible to contract malaria[4]. We further agree with the author that it is likely to take some time before the dose-dependent effect of HCQ countering SARS-CoV-2 infection starts operating *in vivo*[5,6] through effective concentration built-up in the lungs.

We conclude that the currently recommended regimen has some supporting evidence based on laboratory studies and clinical experience of using HCQ for malaria chemoprophylaxis. We also maintain that it would be more appropriate to adhere to stringent use of PPE and preventive measures, such as personal hygiene, social distancing and frequent hand washing along with the currently recommended regimen of HCQ prophylaxis for healthcare workers, until the safety of a higher dose regimen is demonstrated in clinical studies.

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