BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

Drug Treatment Program

Providence HEALTH CARE
How you want to be treated.

PRE-EXPOSURE PROPHYLAXIS (PrEP) ENROLMENT & PRESCRIPTION REQUEST

Please return completed form as per instructions on reverse:
By Fax: 604-806-9044, Telephone: 604-806-8515

OFFICE USE ONLY **PrEP #** _____

Patient and Prescriber Information

Patient: (Legal First or Given Names)	(Legal Last Name)	Telephone:

Patient's Address:	Postal Code	Personal Health Number or Other Billing #

Sex: ☐ Male ☐ Female **Transgender:** ☐ M to F ☐ F to M **Date of Birth:** DD____ MON____ YYYY_____

Pick-up site: ☐ St. Paul's Hospital Ambulatory Pharmacy ☐ Prescriber's Office (outside Greater Vancouver): _____

Prescribing Physician/Name of Provider:

Name:
Address:

College ID number:
MSC number:
Telephone:
Fax:

Follow-up prescriber to order medication refills (if different from the physician noted above).

Name: _____ MSC#: _____ Address: _____ Tel: _____

Patient Information

Ethnicity:
Does this individual self-identify as an Aboriginal person, that is, First Nations, Métis or Inuit?
☐ Yes ☐ No ☐ Unknown

HIV Transmission Risk Factors (*check all that apply*)

Men who have sex with men (MSM)/ Transgender women:
- ☐ HIV Risk Index Score (HIRI-MSM) ≥ 10 (Score:_____)
- ☐ Prior Bacterial Rectal STI/Syphilis
- ☐ Recurrent PEP Use

<u>Known</u> HIV+ partner not on stable ART and/or viral load not < 200 copies/mL:
- ☐ MSM
- ☐ Heterosexual
- ☐ Injection Drug Use

Public Health:
- ☐ Targeted PrEP

Other risk (specify):
_____
_____

Most recent bloodwork result:
Creatinine: _____ DD____ MON_____ YYYY_____
eGFR: _____ DD____ MON_____ YYYY_____

Negative HIV Serology: DD____ MON_____ YYYY_____
*(4th generation HIV test **within past 15 days**)*
Hepatitis B SAg Positive: ☐Yes ☐No

Prior PrEP: ☐ No ☐ Yes ☐ Continuing ☐ Restarting

Drug Allergy: ☐ None Known ☐ Yes (specify): _____

Medication Prescription

Emtricitabine-Tenofovir DF 200-300mg tablet. Take one tablet once daily.

☐ 30 Tablets (for first time PrEP prescriptions) ☐ 90 Tablets

Prescriber's signature: _____ **MSC#:** _____ **Date:** DD____ MON_____YYYY_____

BC-CfE use only:
Prescription Expiry Date: (30 days after authorization) _____ **Authorized by:** _____
DO NOT DISPENSE AFTER EXPIRY DATE

How to complete a form for HIV Pre-exposure Prophylaxis (PrEP)

In British Columbia, Emtricitabine-Tenofovir DF 200-300mg tablet is provided at no cost to qualifying patients through the BC Centre for Excellence in HIV/AIDS (BC-CfE) PrEP Program. For program eligibility criteria, please refer to the BC-CfE website **www.cfenet.ubc.ca**, **"Healthcare Providers"** section which includes current PrEP Guidelines, details about how to calculate the MSM Risk Index Score (HIRI-MSM risk score), medication information and more.

Complete and submit the PrEP Program Enrolment & Prescription Request in the following circumstances:

- New patient, not previously receiving PrEP through the BC-CfE Program.
- Patient has previously received PrEP through the BC-CfE, but who has been off therapy or living outside BC for more than 6 months.

1) PRESCRIBER: COMPLETE THE FORM

- Provide complete patient identifier and prescriber information as required for a legal prescription.
- Include recent HIV serology using a 4th generation HIV test and **(must be negative within previous 15 days of application to qualify)**, estimated GFR, and documented hepatitis B surface antigen status.
- Identify the **follow-up prescriber:** The Physician or Nurse Practitioner who will provide ongoing care and monitoring and authorize prescription refills. Prescription refill forms and other documents will be sent to the enrolling prescriber if no follow-up prescriber is specified.
- **A first-time PrEP prescription is limited to a 30-day supply, and a maximum of 90 day supply can be released for subsequent prescriptions or continuations.**

2) PRESCRIBER: SUBMIT THE FORM FOR BC-CfE AUTHORIZATION

Keep a copy of the prescription for your records. FAX prescription request to:

BC-CfE Drug Treatment Program:
Room 608-1081 Burrard Street, Vancouver BC V6Z 1Y6
Fax: 604-806-9044

- A letter confirming prescription approval will be sent to the prescribing physician and designated follow up prescriber.
- When confirmation is received, **it is the responsibility of the prescriber to inform the patient where to pick up medication.**
- Updated negative HIV status (using 4th generation assay) is required prior to each prescription fill and it is the responsibility of the prescriber to verify these results prior to PrEP initiation and continuation.

3) PATIENT: ARRANGE MEDICATION PICK UP

It is the responsibility of the patient or care-giver to pick up the medication from the designated location within 30 days of the date of authorized prescription.

Authorized pharmacy:
St. Paul's Hospital Ambulatory Pharmacy; 163-1081 Burrard St, Vancouver V6Z 1Y6 Tel: 1-800-547-3622

For individuals living outside the Greater Vancouver area, medications may be shipped to the office of the prescriber if specified.

Glossary:
PrEP - Pre-exposure Prophylaxis
PEP - Post-exposure Prophylaxis
MSM - Men who have sex with men