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

Drug Treatment Programs

Providence Health Care

PRE-EXPOSURE PROPHYLAXIS (PrEP) ENROLMENT & PRESCRIPTION REQUEST

BC-CfE USE ONLY
PrEP # _____

Please return completed form by Fax: 604-806-9044
BC-CfE Drug Treatment Programs
B687-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Tel: 604-806-8515

Client and Prescriber Information

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

Client Address:	Postal Code:	Personal Health Number or Other Billing #:

Sex at Birth:	Gender Identity:	Date of Birth:
☐ Male ☐ Female	☐ Man ☐ Woman ☐ Other: _____	DD-MON-YYYY

Prescriber Information:

Name:

Address:

College ID number (CPSID):

MSP number:

Telephone:

Fax:

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

Name: _____ MSP#: _____ Address: _____ Tel: _____

Client Information

Does this individual self-identify as an Indigenous person? ☐ Yes ☐ No ☐ Unknown ☐ Prefer not to answer
If Yes, ☐ First Nations ☐ Métis ☐ Inuit ☐ Other: _____

What ethnic group or family background does this individual identify with? (Check all that apply)
☐ Black ☐ East Asian ☐ Latin American ☐ Middle Eastern ☐ South Asian ☐ Southeast Asian
☐ White ☐ Other: _____ ☐ Unknown ☐ Prefer not to answer

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

- **Men who have sex with men (MSM)/Transfeminine person:**
  - ☐ HIV Risk Index Score (HIRI-MSM) ≥ 10 **(Score:_____)**
  - ☐ Prior Bacterial Rectal STI/Syphilis
  - ☐ HIV Post-Exposure Prophylaxis ≥ 2 times
- **Client has <u>partner living with HIV</u>: not consistently taking ART, HIV viral load not <200 c/mL, or unable to verify.**
  - **Relationship with partner living with HIV:**
  - ☐ MSM ☐ Heterosexual ☐ Sharing Injection Equipment
- **Clinically assessed risk** (specify): _____

_____

Most recent bloodwork: **Test Date (DD-MON-YYYY):**

Creatinine: _____ _____

eGFR: _____ _____

Negative HIV Serology: _____
*(4th generation HIV test **within past 15 days**)*

Chronic Hepatitis B (Hep B SAg positive): ☐ Yes ☐ No

Prior PrEP: ☐ No ☐ Yes ☐ Continuing ☐ Restarting

Drug Allergy (specify): _____

_____

Medication Prescription *(If medication change requested, please provide reason(s) below with supporting documentation)*

Emtricitabine-Tenofovir DF 200-300mg tablet.

☐ **Take one tablet once daily**

☐ _____

Other: _____

_____

Quantity:
☐ 30 ☐ 44 (for 1st time PrEP Prescriptions)
☐ 60 ☐ 90

Requested Pick-up Date:

Pick-up site: ☐ SPH Pharmacy ☐ Other approved site (specify): _____

Prescriber signature: _____ **MSP#:** _____ **Date:** _____

BC-CfE use only:
Prescription void after (date): _____ **Authorized by / date:** _____

For more information please visit: www.bccfe.ca