

## Drug Treatment Program DOXYCYCLINE FOR SEXUALLY TRANSMITTED INFECTION (STI) PREVENTION (DOXY-PEP) ENROLMENT & PRESCRIPTION FORM

Please return completed form  
**by Fax 604-806-9044**  
BC-CfE Drug Treatment Program  
687-1081 Burrard Street, Vancouver, BC, V6Z 1Y6  
Telephone: 604-806-8515

BC-CfE USE ONLY

**STIP ID #**

**CFE/PrEP ID #**

STI Prevention Initial Enrolment

STI Prevention Prescription Refill

**Patient & Prescriber Information**

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

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

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

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

If the individual does not self-identify as an Indigenous person, how does this individual self-identify? (Check all that apply)

Black  East Asian  Latin American  Middle Eastern  South Asian  Southeast Asian  
 White  Other:   Unknown  Prefer not to answer

Prescriber Name:  College ID number (CPSID):  MSP#:   
Prescriber Address:  Telephone:   
Fax:

DRAFT

**Initial Program Eligibility** Program information can be found at [bc-cfe.ca/drug-treatment-program](http://bc-cfe.ca/drug-treatment-program)

**BC-CfE Drug Treatment Program participant:**  Justly enrolled in one of the following programs  
 HIV Pre-Exposure Prophylaxis Program (HIV PrEP) or  HIV Treatment Program (person living with HIV)

**Identifies with one of the following**  
 Gay, bisexual and other men who have sex with men or  Transgender woman

If other group, provide clinical justification:

**STI risk: (Select all that apply)**  
 History of bacterial STI in the past year and / or  Clinically assessed increased risk of STI

**Medical Information**

<p><b>Most recent STI screening test date:</b> <input style="width: 100%; height: 20px;" type="text"/> DD MON YYYY</p> <p><input type="checkbox"/> <b>Confirmed no currently active STI</b> (prior to starting doxycycline prophylaxis)</p>	<p><b>Most recent STI(s) diagnosed in the past 12 months (check all that apply):</b></p> <p><input type="checkbox"/> None <input type="checkbox"/> Syphilis <input style="width: 100px;" type="text"/> DD MON YYYY</p> <p><input type="checkbox"/> Chlamydia <input style="width: 100px;" type="text"/> DD MON YYYY</p> <p><input type="checkbox"/> Gonorrhoea <input style="width: 100px;" type="text"/> DD MON YYYY</p>	<p><b>Drug Allergies/ Intolerance (specify):</b></p> <p><input type="checkbox"/> None</p>
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**Medication Prescription**

**Doxycycline 100 mg capsule or tablet** **Take two capsules or tablets (2 x 100 mg) as soon as possible (up to 72 hours) after condomless sex. Maximum 200 mg per 24 hours.**

**Quantity:** Initial prescription  30  60  100 capsules / tablets  
Continuation  30  60  100 capsules / tablets

**Pick-up site:**  St. Paul's Hospital Ambulatory Pharmacy, #163-1081 Burrard Street, Vancouver BC, Telephone: 1-800-547-3622 **Please specify pick-up date:**   
 Healthcare site (outside Vancouver):

**Prescriber's signature:**  **MSC#:**  **Date:**

BC-CfE USE ONLY **Reviewer Initials:**  **Date:**