BRITISH COLUMBIA
CENTRE *for* EXCELLENCE
in HIV/AIDS

Providence HEALTH CARE
How you want to be treated.

Drug Treatment Program

PRE-EXPOSURE PROPHYLAXIS (PrEP) ENROLMENT & PRESCRIPTION REQUEST

OFFICE USE ONLY **PrEP #** ______

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

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 at Birth:	**Gender Identity:**	**Date of Birth:**
☐ Male ☐ Female	☐ Male ☐ Female ☐ Other: ______	DD____ MON____ YYYY________

Prescriber Information:
Name:
Address:

College ID number:
MSC number:
Telephone:
Fax:

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

Name: ______ MSC#: ______ Address: ______ Tel: ______

Patient Information

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

If the individual does not self-identify as an Indigenous person, which ethnicity does this individual self-identify with?
☐ White ☐ Asian ☐ Hispanic ☐ Black
☐ Other: ______ ☐ Unknown

HIV Acquisition 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
- ☐ HIV Post-Exposure Prophylaxis ≥ 2 times

Patient has known HIV+ partner, who does not consistently take ART and/or HIV viral load is not <200 c/mL.

Partner Relationship:
☐ MSM ☐ Sharing Injecting Equipment
☐ Heterosexual

Clinically assessed 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***)

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

Prior PrEP: ☐ No ☐ Yes → ☐ Continuing ☐ Restarting

Drug Allergy (specify)**:** ______

Medication Prescription

Emtricitabine-Tenofovir DF 200-300mg tablet. ☐ **Take one tablet once daily**
☐ **Other directions:** ______

☐ 30 or ☐ 44 Tablets (for first time PrEP prescriptions) ☐ 60 Tablets ☐ 90 Tablets

Pick-up site: ☐ SPH Pharmacy ☐ Healthcare provider (outside Vancouver): ______

Prescriber's signature: ______ **MSC#:** ______ **Date:** DD____ MON______ YYYY_______

BC-CfE use only:
Prescription Expiry Date: ______ **Authorized by (date):** ______
(30 days after date of signature) **DO NOT DISPENSE AFTER EXPIRY DATE**

v.24-SEPT-2021

How to complete the PrEP Enrolment & Prescription Request form

In British Columbia, Emtricitabine-Tenofovir DF 200-300mg tablets for PrEP are 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.bccfe.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 BC-CfE
- Returning to BC-CfE supplied PrEP after either having moved out of BC, received drug from another source, been off therapy, or greater than 6 months lapse in PrEP refill
- Also, when transitioning from PEP to PrEP, or requesting a product where a lower cost alternative is available.

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 **(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 30-44 day supply, and a maximum of 90 day supply can be released for subsequent prescriptions or continuations.**
- Specify the prescription pick-up site where the patient will receive medication (see 3, below).

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 687-1081 Burrard Street, Vancouver BC V6Z 1Y6
Fax: 604-806-9044

- A letter confirming prescription authorization and processing will be sent to the requesting prescriber 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 recommended prior to each prescription fill and it is the responsibility of the prescriber to verify these results prior to PrEP initiation and continuation.

3) ARRANGE MEDICATION PICK-UP BY PATIENT

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 Vancouver, delivery of PrEP medication to a healthcare provider or community pharmacy can be arranged by calling 1-800-547-3622.