Manitoba

MEDICATION COVERAGE AND PRESCRIPTION FORM Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP): Adult and Pediatric 13 Years and Older AND Weighing at Least 30 kg

Patient Name: ..... Date: DD/MMM/YYYY

Date of Birth: ..... PHIN: .....

Address: .....

Is patient enrolled in an insurance program with 100% coverage (e.g. federal drug program, Employment and Income Assistance, private insurance program) other than Pharmacare?

☐ **Yes – Client is enrolled in a federal Non-Insured Health Benefits program (NIHB), Employment Income Assistance, private insurance program with 100% coverage, or is eligible for Workers Compensation and is not eligible for the Manitoba HIV Medication Program. Provide prescription as usual.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medication Program. If the client is not enrolled in one of the insurance programs described in the question above, check this box when submitting.**

Complete Prescription below OR attach prescription*

☐ **Bubble pack** ☑ indicates medication is to be dispensed by pharmacy

☑ **raltegravir (RAL) 400 mg tablet (Note: no dosing adjustment required for raltegravir regardless of renal function)**

Directions: ONE tablet by mouth TWICE daily
Dispense: 50 tablets (meets EDS part 2)

AND SELECT ONE OF THE FOLLOWING based on renal function:

☐ **emtricitabine (FTC)/tenofovir (TDF) 200 mg/300 mg tablet** (Normal renal function)

Directions: ONE tablet by mouth ONCE daily
Dispense: 25 tablets (meets EDS part 2)

OR

☐ **lamivudine (3TC)/zidovudine (ZDV) 150 mg/300 mg tablet** (Reduced renal function with creatinine clearance less than or equal to 59 mL/min/1.73 m^2)

Directions: ONE tablet by mouth TWICE daily
Dispense: 50 tablets (meets EDS part 2)

Please note: HIV PEP regimen should include raltegravir 400mg AND emtricitabine 200mg/tenofovir disoproxil fumarate 300mg OR raltegravir 400mg AND lamivudine 150mg /zidovudine 300mg.

Patient received HIV PEP starter kit for 3 days on date: DD/MMM/YYYY

Prescriber Signature_____

Printed Name _____ **License Number**_____

☐ **Faxed** **Date** DD/MMM/YYYY **Time** _____ (24 hour)

Pharmacy Name_____ **Pharmacy Fax #** _____

Prescription can be faxed to only one pharmacy of the patient's choice. Check "Faxed", and fill in the date and time above. Original to be filed permanently in the patient chart. Copy may be provided to patient or caregiver, stamped "COPY", so that prescription cannot be filled at any other pharmacy.

Practitioner certification for faxed prescription: This prescription represents the original of the prescription drug order. The pharmacy addressee noted above is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed and will not be transmitted elsewhere at another time. This fax is confidential and is intended to be received by the addressee only. If the reader is not the intended recipient thereof, you are advised that any dissemination, distribution, or copying of this facsimile is Strictly Prohibited.

Manitoba

MEDICATION COVERAGE AND PRESCRIPTION FORM: Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP): Pediatric Aged 2 to Less than 6 Years Weighing 9 to 34.9 kg

Patient Name: ..... Date: DD/MMM/YYYY

Date of Birth: ..... PHIN: .....

Address: ..... Weight..... kilograms

Is patient enrolled in an insurance program with 100% coverage (e.g. federal drug program, Employment and Income Assistance, private insurance program) other than Pharmacare?

☐ **Yes – Client is enrolled in a federal Non-Insured Health Benefits program (NIHB), Employment Income Assistance, private insurance program with 100% coverage, or is eligible for Workers Compensation and is not eligible for the Manitoba HIV Medication Program. Provide prescription as usual.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medication Program. If the client is not enrolled in one of the insurance programs described in the question above, check this box when submitting.**

***Complete Prescription below OR attach pediatric prescription** Renal dosing adjustments are not required for this age and weight group.*

☑ Indicates to dispense 25 days of each selected drug, with zero refills. Patient given 3 days on date: DD/MMM/YYYY

☐ 30 – 34.9 kg
- lamiVUDine 150 mg *by mouth TWICE daily*
- zidovudine 300 mg *by mouth TWICE daily*
- lopinavir 300 mg/ritonavir 75 mg *by mouth TWICE daily*

☐ 25 – 29.9 kg
- lamiVUDine 150 mg *by mouth TWICE daily*
- zidovudine 200 mg *by mouth in the morning and* 300 mg *by mouth at bedtime*
- lopinavir 300 mg/ritonavir 75 mg *by mouth TWICE daily*

☐ 20 – 24.9 kg
- lamiVUDine 75 mg *by mouth in the morning and* 150 mg *by mouth at bedtime*
- zidovudine 200 mg *by mouth twice daily*
- lopinavir 200 mg/ritonavir 50 mg *by mouth TWICE daily*

☐ 15 – 19.9 kg
- lamiVUDine 75 mg *by mouth twice daily*
- zidovudine 100 mg *by mouth in the morning* and 200 mg *by mouth at bedtime*
- lopinavir 200 mg/ritonavir 50 mg *by mouth TWICE daily*

☐ **Patient unable to swallow whole tablets – dispense lopinavir/ritonavir as oral solution**

☐ 9 – 14.9 kg dispense all medications as liquids
- lamiVUDine _____ mg *by mouth twice daily* (4 mg/kg/**dose**)
- zidovudine _____ mg *by mouth twice daily* (9 mg/kg/**dose**)

lopinavir/ritonavir _____mg (12 mg/kg/**dose** lopinavir component) *by mouth twice daily*

Prescriber Signature_____

Printed Name _____**License #**_____

☐ **Faxed** **Date** DD/MMM/YYYY **Time** _____ (24 hour)

Pharmacy Name_____ **Pharmacy Fax #** _____

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Manitoba

MEDICATION COVERAGE AND PRESCRIPTION FORM: Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP): Pediatric Aged 6 to Less than 13 Years, Weighing at Least 15 kg, with Normal Renal Function

Patient Name: ..... Date: DD/MMM/YYYY

Date of Birth: ..... PHIN: .....

Address: ..... Weight..... kilograms

Is patient enrolled in an insurance program with 100% coverage (e.g. federal drug program, Employment and Income Assistance, private insurance program) other than Pharmacare?

☐ **Yes – Client is enrolled in a federal Non-Insured Health Benefits program (NIHB), Employment Income Assistance, private insurance program with 100% coverage, or is eligible for Workers Compensation and is not eligible for the Manitoba HIV Medication Program. Provide prescription as usual.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medication Program. If the client is not enrolled in one of the insurance programs described in the question above, check this box when submitting.**

***Complete Prescription below OR attach pediatric prescription** Below prescription is for patients with normal renal function defined as creatinine clearance greater than 59 mL/min/1.73 m².*

☑ Indicates to dispense 25 days of each selected drug, with zero refills. Patient given 3 days on date: DD/MMM/YYYY

☐ 35 kg and greater
- emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg *by mouth ONCE daily*
- raltegravir 400 mg *by mouth TWICE daily*

☐ 30 – 34.9 kg
- lamiVUDine 150 mg/zidovudine 300 mg *by mouth TWICE daily*
- raltegravir 400 mg *by mouth TWICE daily*

☐ 25 – 29.9 kg
- lamiVUDine 150 mg *by mouth TWICE daily*
- zidovudine 200 mg *by mouth in the morning and* 300 mg *by mouth at bedtime*
- raltegravir 400 mg *by mouth TWICE daily*

☐ 20 – 24.9 kg
- lamiVUDine 75 mg *by mouth in the morning and* 150 mg *by mouth at bedtime*
- zidovudine 200 mg *by mouth TWICE daily*
- lopinavir 200 mg/ritonavir 50 mg *by mouth TWICE daily*

☐ 15 – 19.9 kg
- lamiVUDine 75 mg *by mouth TWICE daily*
- zidovudine 100 mg *by mouth in the morning and* 200 mg *by mouth at bedtime*
- lopinavir 200 mg/ritonavir 50 mg *by mouth TWICE daily*

☐ **Patient 15 to 24.9 kg and unable to swallow whole tablets – dispense lopinavir/ritonavir as oral solution**

Prescriber Signature_____

Printed Name _____**License #**_____

☐ **Faxed** **Date** DD/MMM/YYYY **Time** _____ (24 hour)

Pharmacy Name_____ **Pharmacy Fax #** _____

Practitioner certification for faxed prescription: This prescription represents the original of the prescription drug order. The pharmacy addressee noted above is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed and will not be transmitted elsewhere at another time. This fax is confidential and is intended to be received by the addressee only. If the reader is not the intended recipient thereof, you are advised that any dissemination, distribution, or copying of this facsimile is Strictly Prohibited.

Manitoba

MEDICATION COVERAGE AND PRESCRIPTION FORM: Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP): Pediatric Age 6 to Less than 16 years, Weighing 15 to 30 kg, with Renal Dysfunction

Patient Name: ..... Date: DD/MMM/YYYY

Date of Birth: ..... PHIN: .....

Address: ..... Weight..... kilograms

Is patient enrolled in an insurance program with 100% coverage (e.g. federal drug program, Employment and Income Assistance, private insurance program) other than Pharmacare?

☐ **Yes – Client is enrolled in a federal Non-Insured Health Benefits program (NIHB), Employment Income Assistance, private insurance program with 100% coverage, or is eligible for Workers Compensation and is not eligible for the Manitoba HIV Medication Program. Provide prescription as usual.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medication Program. If the client is not enrolled in one of the insurance programs described in the question above, check this box when submitting.**

Complete Prescription below OR attach pediatric prescription** Below prescription is for pediatric patients 6 to less than 16 years, weighing 15 – 30 kg, with renal dysfunction, defined as creatinine clearance less than or equal to 59 mL/min/1.73 m^2. For patients who are 13 years or older and at least 30 kg, use prescription form "Adult and Pediatric 13 Years and Older AND Weighing at Least 30 kg"**

☑ Indicates to dispense 25 days of each selected drug, with zero refills. Patient given 3 days on date: DD/MMM/YYYY

☐ **13 years to less than 16 years, weighing 25 to 29.9 kg with renal dysfunction**
- lamiVUDine 150 mg *by mouth TWICE daily*
- zidovudine 200 mg *by mouth in the morning* and 300 mg *by mouth at bedtime*
- raltegravir 400 mg *by mouth TWICE daily*

☐ **13 years to less than 16 years, weighing 20 to 24.9 kg with renal dysfunction**
- lamiVUDine 75 mg *by mouth in the morning* and 150 mg *by mouth at bedtime*
- zidovudine 200 mg *by mouth TWICE daily*
- raltegravir 400 mg *by mouth TWICE daily*

☐ **13 years to less than 16 years, weighing 15 to 19.9 kg with renal dysfunction**
- lamiVUDine 75 mg *by mouth TWICE daily*
- zidovudine 100 mg *by mouth in the morning* and 200 mg *by mouth at bedtime*
- raltegravir 400 mg *by mouth TWICE daily*

☐ **6 years to less than 13 years, weighing 35 kg and greater with renal dysfunction**
- lamiVUDine 150 mg/zidovudine 300 mg *by mouth TWICE daily*
- raltegravir 400 mg *by mouth TWICE daily*

6 years to less than 13 years, weighing less than 35 kg – no adjustment for renal dysfunction; use *Pediatric Age 2 to Less than 6 Years of Age weighing 9 to 34.9 kg* prescription

Prescriber Signature_____

Printed Name _____**License #**_____

Faxed **Date** DD/MMM/YYYY **Time** _____ (24 hour)

Pharmacy Name_____ **Pharmacy Fax #** _____

Practitioner certification for faxed prescription: This prescription represents the original of the prescription drug order. The pharmacy addressee noted above is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed and will not be transmitted elsewhere at another time. This fax is confidential and is intended to be received by the addressee only. If the reader is not the intended recipient thereof, you are advised that any dissemination, distribution, or copying of this facsimile is Strictly Prohibited.

September 2022

Manitoba HIV Medication Program Eligibility and Claims Procedure

Eligibility: Manitoba residents with HIV PEP indication (per protocol below) who have an active Manitoba Health Coverage and are not currently enrolled in a full medication coverage program (100% coverage) are eligible for coverage under this program. Inability to confirm a patient's current medication coverage will be considered equivalent to no coverage, and entitles the patient to coverage under the Manitoba HIV Medication Program. Patients enrolled in Manitoba Pharmacare are eligible for coverage under this program.

Post-Exposure Prophylaxis for HIV, HBV and HCV: Integrated Protocol for Managing Exposure to Blood and Body Fluids in Manitoba: https://www.gov.mb.ca/health/publichealth/cdc/protocol/hiv_postexp.pdf

Pharmacy Claims Submission Procedure

The following Claims Submission Procedure (CSP) is for prescriber reference only. As the department may update the CSP from time to time, pharmacies are expected to follow the current version of CSP in place on the date of filling the prescription. The current CSP is available online at:
https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html

Information for Pharmacists

Claims Submission Procedure

Manitoba HIV Medication Program – Post-Exposure Prophylaxis (PEP)

Effective July 26, 2021

Please include this Procedure in your Drug Programs Information Network (DPIN) Manual under Section 4: Claims Submission.

- This Claims Submission Procedure (CSP) applies to community pharmacy dispensation of medications listed on the Manitoba HIV Medication Program Drug List to eligible Manitoba residents:
  - with active Manitoba Health coverage; AND
  - a completed HIV PEP Prescription Form – available here for reference: https://www.gov.mb.ca/health/publichealth/cdc/protocol/hiv_prescription.pdf; prescribing one or more PEP drugs listed on the Manitoba HIV Medication Program Drug List, available here: https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html The prescriber may also attach separate prescriptions for PEP drug(s) not shown on the HIV PEP Prescription Form.

- Where a patient presents with a completed HIV PEP Prescription Form (and separate attached prescriptions for PEP, if applicable) and the prescriber has confirmed "**Client eligible for coverage under Manitoba HIV Medication Program**" on the form, the patient should not be charged any out-of-pocket costs.

- This CSP must be followed for reimbursement of the allowable ingredient cost plus the pharmacy's usual & customary professional fee:
  - For drugs prescribed for PEP, ensure the prescriber has confirmed "**Client eligible for coverage under Manitoba HIV Medication Program"** on the HIV PEP Prescription Form.
  - EACH time a drug is intended to be dispensed under this program, contact the DPIN Helpdesk to confirm:
    1. that the patient has active Manitoba Health coverage; AND
    2. whether the pharmacy should submit the claim under DU only OR for fiscal adjudication

  <u>If the DPIN Helpdesk advises to submit the claim to DPIN as Drug Utilization (DU) only:</u>

  - Do not provide prescription receipts to clients for medications submitted to the Manitoba HIV Medication Program.
  - AFTER the medication has been dispensed to the patient at no charge, submit a Reversal/Adjustment Form for reimbursement to the pharmacy as follows:
    1. Use one DPIN Reversal-Adjustment Form per prescription (available here: https://www.gov.mb.ca/health/pharmacare/profdocs/ra_form.pdf)
       - For clarity, if more than one drug is prescribed within one HIV PEP Prescription Form, the pharmacy must submit one Reversal-Adjustment Form for each drug dispensed.

2. Write “Meets MB HIV Medication Program Eligibility” clearly on the top of the Reversal/Adjustment Form.
3. Enter a professional fee equal to the pharmacy’s usual & customary professional fee, and an ingredient cost of the drug as per the Manitoba Drug Interchangeability Formulary (ICF); or as per the Manitoba HIV Medication Program Drug List, for drugs not listed on the ICF.
4. Fax the completed Reversal/Adjustment Form to DPIN Helpdesk with a cover letter, the HIV PEP Prescription Form, and a copy of the attached separate prescription (if applicable) to the attention of “Manitoba HIV Medication Program” via 204-786-6634.

Reversal/Adjustment Forms cannot be submitted to DPIN Helpdesk until AFTER the medication has been dispensed to patient.

- Pharmacy operators will be reimbursed an amount equal to the ingredient cost of the drug (as per the ICF; or as per the Manitoba HIV Medication Program Drug List, for drugs not listed on the ICF) in DPIN plus the usual & customary professional fee identified in Schedule A/B of the Pharmacy Agreement.

- Subsequent to processing by DPIN Helpdesk, claims will appear on the pharmacy statement and be reimbursed via electronic fund transfer.

- Failure to submit the claim according to the procedure above will result in no reimbursement to the pharmacy for the allowable ingredient cost nor the pharmacy’s usual & customary professional fee.

If your questions are not answered by reviewing the Claims Submission Procedures and FAQs posted at:
https://www.gov.mb.ca/health/pharmacare/healthprofessionals.html

Please send e-mail to PDPInfoAudit@gov.mb.ca