Human Immunodeficiency Virus
Post-Exposure Prophylaxis Prescription Form

Manitoba
Health, Seniors and Active Living

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Patient Name: ..... Date: .....

Date of birth: ..... PHIN: ..... Gender: M / F

Address: .....

*** Prescriber to tick the checkbox of the applicable drug/s below. Use separate prescription for drug/s not shown.***

☐ **emtricitabine/tenofovir (Truvada®) 200 mg/300 mg tablet** *Sig:* **1** tablet by mouth once daily (Substitutions allowed)	**QTY:** ..... tablet/s **Refill/s:** ..... QTY in starter kit/s*: ..... tablets
☐ **lamivudine/zidovudine (Combivir®) 150 mg/300 mg tablet** *Sig:* **1** tablet by mouth twice daily (Substitutions allowed)	**QTY:** ..... tablet/s **Refill/s:** ..... QTY in starter kit/s*: ..... tablets
☐ **zidovudine (Retrovir®) 100 mg capsule** *Sig:* ___ capsule/s by mouth twice daily (Substitutions allowed)	**QTY:** ..... capsule/s **Refill/s:** ..... QTY in starter kit/s*: ..... capsules
☐ **lamivudine (3TC®) 150 mg tablet** *Sig:* (Substitutions allowed)	**QTY:** ..... tablet/s **Refill/s:** ..... QTY in starter kit/s*: ..... tablets
☐ **raltegravir (Isentress®) 400 mg tablet** *Sig:* **1** tablet by mouth twice daily (Substitutions allowed)	**QTY:** ..... tablet/s **Refill/s:** ..... QTY in starter kit/s*: ..... tablets
☐ **lopinavir/ritonavir (Kaletra®) 100 mg/25 mg tablet** *Sig:* ___ tablet/s by mouth twice daily (Substitutions allowed)	**QTY:** ..... tablet/s **Refill/s:** ..... QTY in starter kit/s*: ..... tablets

Drug use: For post-exposure prophylaxis (PEP) to prevent infection subsequent to exposure to human blood and body fluids that may transmit human immunodeficiency virus (HIV)

FOR PHARMACY USE ONLY

This prescription is:

- O New prescription
- O Addition to previous prescription
- O Replace previous prescription
- O Begin after previous prescription complete

Additional dispensing information:

*Prescription VOID if total number of days equivalent of quantity taken or expected to be taken from any and all starter kit/s provided PLUS quantity prescribed (including any refills) **exceed 28 days**.

Prescriber Signature: .....

Prescriber Name: ..... M.D.

License No.: .....

Address: .....

.....

Tel.: ..... Fax: .....