July 2024

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 has 100% coverage through enrollment in a federal program such as Non-Insured Health Benefits (NIHB), or a provincial program such as Employment Income Assistance, or Workers Compensation. Provide prescription as usual with costs billed to these programs. Client is not eligible for the Manitoba HIV Medications Program.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medications 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.

July 2024

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 has 100% coverage through enrollment in a federal program such as Non-Insured Health Benefits (NIHB), or a provincial program such as Employment Income Assistance, or Workers Compensation. Provide prescription as usual with costs billed to these programs. Client is not eligible for the Manitoba HIV Medications Program.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medications 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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July 2024

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 has 100% coverage through enrollment in a federal program such as Non-Insured Health Benefits (NIHB), or a provincial program such as Employment Income Assistance, or Workers Compensation. Provide prescription as usual with costs billed to these programs. Client is not eligible for the Manitoba HIV Medications Program.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medications 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 m^2.***

☑ 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)

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July 2024

MEDICATION COVERAGE AND PRESCRIPTION FORM: Human Immunodeficiency Virus (HIV) Post-Exposure Prophylaxis (PEP): Pediatric Age 6 to Less than 16 years, 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 has 100% coverage through enrollment in a federal program such as Non-Insured Health Benefits (NIHB), or a provincial program such as Employment Income Assistance, or Workers Compensation. Provide prescription as usual with costs billed to these programs. Client is not eligible for the Manitoba HIV Medications Program.**

☐ **No – Client meets eligibility criteria for Manitoba HIV Medications 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, with renal dysfunction, defined as creatinine clearance less than or equal to 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

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*"

☐ **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 prescription form "*Pediatric Aged 6 to Less than 13 Years, Weighing at Least 15 kg, Normal Renal Function*"

Prescriber Signature_______________________________________

Printed Name ____**License #**__________________

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

Pharmacy Name_______________________________________ **Pharmacy Fax #** ___________________________

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