Pre-Exposure Prophylaxis (PrEP) Self-screening Form

Date: _____ / _____ /_____

Name (First, Last): _____ **Phone #:** _____

Chosen Name: _____ **Language(s):** _____

Address: _____ **Interpreter Services Needed** □

Date of Birth: _____ / _____ /_____ **Pronouns:** _____

Sex Assigned at Birth: _____ **Gender:** _____ **Weight:** _____ Kg Ib (circle one)

Ethnicity: Hispanic Non-Hispanic **Race:** _____ **Height:** _____ cm in (circle one)

Primary Medical Insurance Plan: _____

Address: _____
Policy / Group Number: _____/_____
Subscriber's Name: _____
Subscriber's Date of Birth: _____ / _____ /_____

Relationship to Subscriber: _____

Prescription Drug Plan: _____

Address: _____
Group / BIN / PCN Number: _____/_____/_____
Subscriber's Name: _____
Subscriber's Date of Birth: _____ / _____ /_____
Relationship to Subscriber: _____

If you are concerned about ability to pay for services or your copay, talk to the pharmacist about being connected to a PrEP Navigator.

Washington State Department of Health

DOH 150-180 December 2022

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Patient Background and Medical History *These questions will help the pharmacy team determine if PrEP is right for you.*		
1. In the past 6 months, have you had a sexual partner who is a: • *Man* • *Woman* • *Transgender person* • *Nonbinary person*	□ Yes □ Yes □ Yes □ Yes	□ No □ No □ No □ No
2. In the past 6 months, have you been in a relationship (or had sex) with someone who is living with HIV?	□ Yes	□ No
3. About how often do you use condoms for sex. _____*% of the time* When was the last time you had sex without a condom? ____/____/____ *last sex without a condom*		
4. Do you have anal sex? • *Receptive (bottoming) - someone uses their penis to perform anal sex on you* • *Insertive (topping) - you use your penis to perform anal sex on someone else*	□ Yes □ Yes □ Yes	□ No □ No □ No
5. Do you have vaginal sex? • *Receptive- you have a vagina and you use it for vaginal sex* • *Insertive- you have a penis and you use it for vaginal sex*	□ Yes □ Yes □ Yes	□ No □ No □ No
6. Have you had a Sexually Transmitted Infection (STI) in the past 6 months? *If yes, please list the STI(s):* _____	□ Yes	□ No
7. In the last 12 months, which drugs have you injected? • *Heroin* □ • *Cocaine* □ • *Methamphetamine (meth or crystal)* □ • *Suboxone* □ • *Methadone* □ • *Other Opiate* □ • *Not listed, please specify* _____ • *None of the above* □		
8. Do you exchange sex for money or goods? (includes paying for sex)	□ Yes	□ No
9. Do you use poppers (inhaled nitrates) and/or methamphetamine?	□ Yes	□ No
10. Have you ever been diagnosed with renal insufficiency? Or kidney problems?	□ Yes	□ No
11. Have you ever been told you were at risk for bone fractures or bone loss?	□ Yes	□ No
12. Do you see a healthcare provider for management of Hepatitis B?	□ Yes	□ No
13. Have you ever received an immunization for Hepatitis B? *If yes, when:* _____/_____/_____ • *If no, would you like a Hepatitis B immunization today?*	□ Yes □ Yes	□ No □ No
14. Are you currently or planning to become pregnant or breastfeeding?	□ Yes	□ No
15. Are you experiencing any of the following symptoms? *Fever, Sore throat, Fatigue, Rash, or Diarrhea?* • *If yes, have you had sex or injected drugs in the past 4 weeks?*	□ Yes □ Yes	□ No □ No
16. Have you been on Pre-Exposure HIV Prophylaxis (PrEP) before? • *If yes, when: Start:* _____/_____/_____ *Stop:* _____/_____/_____ • *Why did you stop taking PrEP?*	□ Yes	□ No
17. Have you ever been on *Non-occupational Post-Exposure HIV Prophylaxis (nPEP)* before?	□ Yes	□ No

• *If yes, when: _____/_____/_____*		
18. Are you currently enrolled in any patient assistance programs, like PrEP Drug Assistance Program (PrEP DAP), Gilead, _____? • *If yes, please bring your enrollment card to your visit.*	□ Yes	□ No
19. Do you currently have a primary care provider? • *If no, the pharmacy team can connect you to one during your visit.*	□ Yes	□ No

Medications

Please write down the names of any prescription or over the counter medications or supplements you take. Please include herbal and nutritional products as well. This helps the pharmacist make sure there are no harmful interactions with your PrEP.

_____

_____

_____

_____

_____

Please list any allergies to medications: _____

Testing and Other Considerations

Today's Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____

Preferred pronouns (circle): He/Him, She/Her, They/Them, Ze/Hir

Type of Visit: Initial 1-month Follow-up 3-month Follow-up Re-Start *(circle one)*

Visit Status: New Start Continuing Re-Start Stop *(circle one)*

Other Considerations: Pharmacist to review these items prior to initiating testing/labs	
Considerations	**Action**
Acute HIV Infection: *(Signs and Symptoms include: Fever, Sore throat, Fatigue, Rash, or Diarrhea)*	☐ Acute HIV Infection is a contraindication for PrEP. If patient has acute HIV infection (answers "yes" to both questions within #15), pharmacist will not prescribe PrEP, but instead: i. Contact your local health jurisdiction and refer the patient for confirmatory testing and linkage to care. ii. Notify Authorizing Prescriber.
Condomless sex in past 2 weeks	☐ Pharmacist will proceed with visit, but counsel patient that HIV lab results from this encounter may be inaccurate due to this recent exposure. HIV testing will be repeated at 1-month follow-up.
Patient <18 years of age	☐ Notify Authorizing Prescriber and proceed with visit. Note that individual must be ≥35 kg or ≥77 lbs to be prescribed PrEP. Adolescents who are under the age of 14, must have parent/guardian consent to obtain services (RCW 70.24.110).
History of kidney disease or osteoporosis	☐ If the patient has a medical history of kidney disease or osteoporosis, the pharmacist will refer the patient to a primary care provider for evaluation prior to initiating PrEP and notify the Authorizing Prescriber that this was done.

Testing: *Pending abnormal result, pharmacist to take the actions (italicized) within table*				
Test	**Date of Test**	**Result**		
Rapid HIV Antibody Test	_____/_____/_____	☐ Reactive	☐ Indeterminate	☐ Negative
	If result Reactive or Indeterminate: Do not prescribe PrEP, instead: ☐ *Report the case to the local health jurisdiction within 3 business days (WAC 246-101). See page 12 for reporting forms and further detail on process.* ☐ *Refer the patient to the local health jurisdiction for assistance in accessing care/treatment. See page 12 for reporting forms and further detail on process.* ☐ *Notify Authorizing Prescriber.*			
HIV ag/ab Lab-based Test	_____/_____/_____	☐ Reactive	☐ Indeterminate	☐ Negative
	If result Reactive or Indeterminate: Do not prescribe PrEP or Discontinue PrEP, instead: ☐ *Report the case to the local health jurisdiction within 3 business days (WAC 246-101). See page 12 for reporting forms and further detail on process.* ☐ *Refer the patient to the local health jurisdiction for assistance in accessing care/treatment. See page 12 for reporting forms and further detail on process.* ☐ *Notify Authorizing Prescriber.*			
Syphilis Blood Test	_____/_____/_____	☐ Reactive	☐ Indeterminate	☐ Negative
	If result Reactive or indeterminate: Advise patient that they can still initiate or continue PrEP, and: ☐ *Report the case to the local health jurisdiction within 3 business days (WAC 246-101). See page 12 for reporting forms and further detail on process.* ☐ *Refer the patient to the local health jurisdiction for assistance in accessing care/treatment. See page 12 for reporting forms and further detail on process.*			

Gonorrhea/Chlamydia	_____/_____/_____	☐ Reactive	☐ Indeterminate	☐ Negative
	If any (urinalysis, rectal, pharyngeal) result is Reactive or Indeterminate: Advise patient that they can still initiate or continue PrEP, and: ☐ *Report the case to the local health jurisdiction within 3 business days (WAC 246-101). See page 12 for reporting forms and further detail on process.* ☐ *Provide treatment to patient (see 'STI Medication Administration') on page 6.* ☐ *Refer the patient to the local health jurisdiction for assistance in accessing partner care (HIV and STI testing). See page 12 for reporting forms and further detail on process.*			
Hepatitis B surface antigen	_____/_____/_____	☐ Positive	☐ Negative	
	☐ *If result Positive: Refer the patient for primary care evaluation. Advise patient that they should not discontinue PrEP without medical supervision.*			
Hepatitis B surface antibody	_____/_____/_____	☐ Positive	☐ Negative	
	☐ *If Negative Hepatitis B surface antigen <u>and</u> Negative Hepatitis B surface antibody: Offer the patient Hepatitis B vaccine or refer the patient elsewhere to receive immunization and advise the patient to continue PrEP.*			
Renal Function (Creatinine)	_____/_____/_____	☐ <30 ml/min	☐ ≥30 ml/min to <60 ml/min	☐ ≥ 60 mL/min
	☐ *If result <60 ml/min: Refer the patient for primary care evaluation and contact Authorizing Prescriber to discuss plan for whether patient should initiate or continue PrEP.*			
Pregnancy Test (only conducted for patients with a uterus)	_____/_____/_____	☐ Positive	☐ Negative	
	☐ *If result Positive: Refer the patient for primary care evaluation and advise the patient to continue PrEP.* ☐ *Notify Authorizing Prescriber.*			

STI Medication Administration

Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____

Preferred pronouns (circle): He/Him, She/Her, They/Them, Ze/Hir

Encounter: Initial 1-month Follow-up 3-month Follow-up Re-Start *(circle one)*

For patients with reactive gonorrhea and/or chlamydia test results, the pharmacist shall administer treatment as outlined below:

Gonorrhea	Chlamydia
• For patients with uncomplicated genital, rectal, or pharyngeal gonorrhea who weigh <150kg (300 pounds), the pharmacist will provide ceftriaxone, 500 mg as a single intramuscular injection. If chlamydia co-infection has not been ruled out with a negative test, provide doxycycline 100mg orally twice daily. • Counsel patient to abstain from sexual activity for 7 days. • If patient weighs >150kg (300 pounds), the pharmacist will provide ceftriaxone 1 gram as a single muscular injection. • If the patient is allergic to penicillin, refer to the appropriate health department for treatment. • If the patient is pregnant and chlamydia infection has not been ruled out, do not treat with doxycycline. Provide azithromycin 1 gram orally in a single dose and refer patient to their healthcare provider. • If the patient is a woman of childbearing age who is not using highly effective contraception (hormonal or IUD) or had a negative pregnancy test, do not treat with doxycycline. Provide azithromycin 1 gram orally in a single dose.	• For patients with uncomplicated genital, rectal or pharyngeal chlamydia: provide doxycycline, 100 mg orally twice daily for 7 days. • Counsel patient to abstain from sexual activity until completion of the 7 days. • Pregnant patients should not be given doxycycline. ; if pregnant, provide azithromycin 1 gram orally in a single dose and refer patient to their healthcare provider). • If the patient is allergic to doxycycline, pharmacist can provide azithromycin, 1 gram orally in a single dose. • If the patient is a woman of childbearing age who is not using highly effective contraception (hormonal or IUD) or had a negative pregnancy test, do not treat with doxycycline. Provide azithromycin 1 gram orally in a single dose.

Medication Administration			
Medication Name	**Date Medication Administered**	**NDC Number**	**Notes**
_____	_____/_____/_____		
_____	_____/_____/_____		
_____	_____/_____/_____		

Hepatitis B Immunization Administration

Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____

Preferred pronouns (circle): He/Him, She/Her, They/Them, Ze/Hir

Encounter: Initial 1-month Follow-up 3-month Follow-up Re-Start *(circle one)*

For patients with Negative Hepatitis B surface antigen and Negative Hepatitis B surface antibody results, pharmacist shall offer and administer Hepatitis B immunization.

Immunization Administration			
Vaccine Name /Trade Name	**Date Administered**	**NDC Number**	**Notes**
_____	_____/_____/_____		
_____	_____/_____/_____		
_____	_____/_____/_____		

Counseling and PrEP Education

Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____

Preferred pronouns (circle): He/Him, She/Her, They/Them, Ze/Hir

Encounter: Initial 1-month Follow-up 3-month Follow-up Re-Start *(circle one)*

Assuming no contraindications; and prior to dispensing PrEP, pharmacist shall conduct counseling and education specific to PrEP. Pharmacist to review and check off as completed.

	Completed
1. Discussed current knowledge on benefits and risk of PrEP with patient. https://www.cdc.gov/hiv/basics/prep.html	□
2. Provided education about PrEP medication. https://www.cdc.gov/hiv/basics/prep.html	□
3. Provided information about other methods to protect against HIV transmission. https://www.cdc.gov/hiv/basics/prevention.html	□
4. Provided information about other methods to protect against bacterial STI and STI screening recommendations. https://www.cdc.gov/std/prevention/default.htm	□
5. Provided counseling on medication use, dosing, side effects, expectations, and labs required, including the following: • Explained that the patient's lab results, and information will be used by the pharmacist to determine if they should start, continue, or stop taking PrEP. • Explained that an HIV test is needed every 90 days to get their PrEP prescription filled. • Explained that the patient must complete STI screening at least every 3 months while on PrEP. Undiagnosed STIs will increase the risk of getting HIV. • Explained that the patient must complete a renal function (creatinine) test at least every 6 months while on PrEP in order to monitor their kidney function. • Explained that the effectiveness of PrEP is dependent on the patient taking all their doses. Missing doses increases the risk of getting HIV. • Explained that if the patient has sex without a condom within 2 weeks before their HIV test, the results may not be accurate. They will need to repeat the HIV test at their one-month follow-up visit or within a month of their current visit. • Explained that the patient should tell the pharmacist right away if they have stopped or plan to stop PrEP. • Explained that any positive HIV or STI screening tests will be reported to their local health department within 3 working days, in accordance with WAC 246-101.	□ □ □ □ □ □ □
6. Discussed the importance of adherence, potential barriers, and developed an adherence plan.	□
7. Offered patient linkage to a PrEP Navigator, who can provide support to maintain adherence.	□
8. Scheduled 1-month and 3-month follow-up appointment with patient.	□
9. Emphasized the importance of condom use (STI prevention) and, if applicable, safer syringe practices.	□

Prescription

Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____

Preferred pronouns (circle): He/Him, She/Her, They/Them, Ze/Hir

Encounter: Initial 1-month Follow-up 3-month Follow-up Re-Start *(circle one)*

- **Initial and Re-start Visits:** Prescribe a 30-day prescription with no refill
- **1-month and 3-month follow-up visits:** Prescribe a 30-day prescription with up to 2 refills

Contraindications for prescribing PrEP include: (1) Signs/symptoms of acute HIV infection (2) Reactive or indeterminate HIV test (3) History of kidney disease or osteoporosis

Patient Name:
Patient DOB:
Patient Address:
Patient Phone number:
Prescription: emtricitabine-tenofovir disoproxil fumarate 200/300 mg tablets (Take one tablet by mouth daily.) **Quantity**: 30 **Refills**: 0 1 2
Date of Issue:
Prescriber Name and NPI: ***[Pharmacist's Name and NPI]***
Prescriber Address:
Prescriber phone:
Prescriber's Signature ***[Pharmacist's Signature]:*** _____ _____ **Substitution Permitted** **Dispense as Written**

If prescription not provided, reason(s) why: _____

Note: If pharmacist will ever provide this prescription as a hardcopy to the patient, it must be printed on tamper-resistant prescription paper approved by the Board of Pharmacy (RCW 18.64.500 and RCW 69.41.120).

PrEP Stopped

Date _____/_____/_____

Patient Name_____ Date of Birth _____/_____/_____

Preferred pronouns (circle): He/Him, She/Her, They/Them, Ze/Hir

Encounter: Initial 1-month Follow-up 3-month Follow-up Re-Start *(circle one)*

PrEP Stopped: If at any visit, patient indicates that they have stopped PrEP and do not intend to re-start PrEP during the visit, the pharmacist shall ask the following questions:

1. Date PrEP Stopped: _____

2. PrEP Stop Date Uncertain: Yes No

3. Reason patient stopped PrEP (check all that apply):

- ☐ Insurance/Coverage issues
- ☐ Began a monogamous relationship
- ☐ Moved away
- ☐ Felt they were no longer at risk for HIV
- ☐ Ended a relationship with someone living with HIV
- ☐ Side effects
- ☐ They tested positive for HIV
- ☐ They transferred pharmacies or care
- ☐ Other, please specify: _____

After counseling has occurred and PrEP has been dispensed, the pharmacist will end the appointment by:

- Providing linkage/referral to a PCP for patients who do not have one.
- Ensuring all lab results are forwarded to the Authorizing Provider, via lab account.
- Completing visit documentation within EHR, pharmacy panel management platform, or other data capture system(s).

Case Reporting Forms and Follow-up Schedule

Case reporting forms:

- King County:
  - HIV Case Report Form (King Co). https://kingcounty.gov/depts/health/communicable-diseases/health-care-providers/~/media/depts/health/communicable-diseases/documents/hiv-aids-case-reporting-form.ashx
  - STI Case Report Form (King Co). https://kingcounty.gov/depts/health/communicable-diseases/health-care-providers/~/media/depts/health/communicable-diseases/documents/std-case-reporting-form.ashx
- Pierce County:
  - HIV Case Report Form (Pierce Co). https://www.tpchd.org/Home/ShowDocument?id=2538
  - STI Case Report Form (Pierce Co). https://www.tpchd.org/home/showdocument?id=1647
- Snohomish County:
  - HIV Case Report Form (Snoho Co). https://www.snohd.org/DocumentCenter/View/525/HIV-Reporting-Form-PDF
  - STI Case Report Form (Snoho Co). https://www.snohd.org/DocumentCenter/View/4226/SnohomishCountySTDCaseReport-20210707-Fillable?bidId=
- Spokane County:
  - HIV Case Report Form (Spokane Co). https://srhd.org/media/documents/HIVCaseReportForm.pdf
  - STI Case Report Form (Spokane Co). https://srhd.org/media/documents/STDCaseReportForm.pdf
- Washington State Department of Health Case Reporting Information (all other counties):
  - Case Report Forms: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/sexually-transmitted-disease-std/case-reports

Follow-up Appointments and Testing Schedule:

At every follow-up appointment:

- Every 3 months, repeat HIV testing and bacterial STD screening for syphilis, gonorrhea, and chlamydia. If patient is late (no more than 1 month) in returning for follow-up visits and labs, the pharmacist will dispense a 30-day supply of emtricitabine-tenofovir disoproxil fumarate.
- If at any time the patient has signs and symptoms suggestive of acute HIV infection, the pharmacist shall take the actions outlined in section 1, subsection 3 above.
- If at any time the patient has a positive HIV test, the pharmacist shall take the actions outlined in section 6, subsection 1 above.
- If at any time the patient indicates that they have stopped PrEP for 1 month or longer, the pharmacist will initiate care as if the patient is newly starting PrEP. The pharmacist will screen for AHI, repeat the whole blood rapid HIV test, the HIV antigen/antibody test, the bacterial STD screening for syphilis, gonorrhea, and chlamydia STI tests, and collect information on why PrEP was discontinued.
- During any consultation, the pharmacist may also provide patients with recommended vaccines, HIV/STI prevention counseling, contraception counseling, and appropriate over-the-counter medication.
- At every follow-up, reassess any barriers to adherence and provide counseling support as appropriate.

Every 6 months:

- Every 6 months, repeat creatinine blood test.