British Columbia Centre for Excellence in HIV/AIDS

HIV/AIDS DRUG REQUEST PRESCRIPTION FORM

608-1081 Burrard Street Vancouver, BC, V6Z 1Y6 Phone: 604-806-8515 Fax: 604-806-9044

Providence HEALTH CARE

This form is to be completed by the physician at the time of the initial drug request.
For assistance call 1- 800 - 665 -7677

BC-CfE: _____ For office use only

I. PATIENT AND PHYSICIAN INFORMATION

Patient: (First or Given Names)	(Last Name)	Telephone:

Patient's Address:	Postal Code	Personal Health Number or Other Billing #

Sex: ❑ Male ❑ Female ❑ Transgender
Due date if Pregnant (MM/YY): _____

First Nations ❑ yes ❑ no

Height _____ cm
Weight _____ kg

Date of Birth
DD____ MM____ YY____

Preferred prescription pick-up site: ❑ St. Paul's Hospital ❑ Other approved site: _____

Enrolling Physician:
Name: MSC number:
Address:
Postal code: Telephone:

Follow-up physician to receive further Refill Forms (if different from the physician noted above).
Name: _____ MSC#: _____ Address: _____ Tel: _____

II. LABORATORY DATA:

Date of first positive: **HIV serology or antigen** DD____ MM____ YY____
Most recent results: **CD4 Abs** _____ on DD____ MM____ YY____ **Viral Load**_____ on DD____ MM____ YY____

III. OTHER MEDICAL INFORMATION:

Hepatitis C positive: ❑ Yes ❑ No ❑ Unknown
Hepatitis B positive: ❑ Yes ❑ No ❑ Unknown
History of injection drug use: ❑ Yes ❑ No ❑ Unknown
Medication Allergy:_____
Other medical history (medical conditions, non-antiretroviral medications):

IV. MEDICATION REGIMEN Include Special Access, Expanded Access and study medications

Continuing meds from outside BC: ❑ Yes ❑ No

New or continuing medication(s) and dosage:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____

Medication(s) to be discontinued:

1 _____
2 _____
3 _____
4 _____

Reason(s) for medication regimen change

a) ❑ Treatment failure (pVL rebound or CD4 decline)
b) ❑ Regimen simplification
c) ❑ Drug interaction between _____ & _____
d) ❑ Adverse reaction to_____(list drugs)

Describe reaction/ problem: (include relevant lab test results)

reaction onset date: DD____ MM____ YY____

_____
_____
_____

Severity: ❑ mild ❑ moderate ❑ severe ❑ potentially life-threatening
Hospitalization required: ❑ Yes ❑ No
Other possible causes of reaction:_____
_____

e) ❑ Other reason for regimen change:_____

Enrolling Physician's signature: _____ **MSC#:** _____ **Date:** _____

For office use only: **Authorizing signature:** _____ **Authorization date:** _____

Completing the HIV/AIDS Drug Request Prescription Form

In British Columbia, antiretroviral medications and certain other drugs for management of HIV/AIDS are provided at no cost to qualifying patients, through the BC-Centre for Excellence in HIV/AIDS (BC-CfE) Drug Treatment Program. Patients are enrolled in the Drug Treatment Program at the time of their first prescription.

Current Therapeutic Guidelines available at **www.cfenet.ubc.ca**. Physician consultation (**1-800-665-7677**) available 7 days a week. Pharmacist consultation (**1-888-511-6222**) available Mon-Fri 8 am- 4 pm (after hours, a pharmacist is on call for emergency situations).

I. PATIENT AND PHYSICIAN INFORMATION

Patient: Provide complete patient information at enrollment and legal prescription requirements (name, address), current weight and information updates thereafter. If the patient is not yet covered by BC Medical Services Plan, please specify the responsible health insurance agency or provincial plan.

Prescription Pick-up site: Authorized sites include:

Pharmacies in Vancouver: St Paul's Hospital (Ambulatory), Downtown Community Health Clinic, BC Children's Hospital (Outpatient); ***Pharmacies outside Vancouver:*** Eric Martin Pavilion (Victoria), Nanaimo Regional General Hospital, Lakeside Medicine Centre (Kelowna); ***Provincial Prisons and Jails:*** Product Distribution Centre. ***Other sites:*** HIV medications may be delivered to a physician's office or a designated community pharmacy. Call the St. Paul's Hospital pharmacy (604)-806-8456 for further information.

Physician: The "enrolling physician" is the physician completing the prescription form. Prescription refill forms and other documents will be sent to the enrolling physician ***unless*** a "follow-up physician" is specified.

II. LABORATORY DATA

HIV **serology date** is required at enrollment. Current **CD4** count and plasma viral load (**pVL**) results are required with each prescription to ensure antiretroviral efficacy (please attach a copy of the lab report).

III. OTHER MEDICAL INFORMATION

To ensure patient safety, please document **medication allergies** (e.g. abacavir), **medical conditions** (e.g. hepatitis, hepatic or renal impairment) or potentially **interacting medications** (e.g. methadone, anticonvulsants, acid suppressing drugs) which could influence the choice or dosage regimen of antiretroviral medication.

IV. MEDICATION REGIMEN

Continuing meds from outside BC: Check "yes" if the patient has ever been treated with antiretroviral medications prior to enrollment in the BC Drug Treatment Program.

New or continuing medications: Please write the entire antiretroviral medication regimen (both new and continuing drugs) with medication dose and dosage frequency.

Medications to be discontinued: List all medications to be discontinued and document the reason for change.

Reason for medication regimen change: This information helps the BC-CfE authorizing physician ensure that the requested regimen is safe and appropriate for the patient, and contributes to drug safety monitoring.

Submit the completed form:

1) Keep the back copy of the form for your records and mail all other copies to the BC-CfE address at the top (front side) of the form. **Urgent requests may be faxed to the Drug Treatment Program (604)-806-9044.**

2) A BC-CfE physician will ensure that the prescription is compatible with current Therapeutic Guidelines, and will contact the prescribing physician if clarification is required.

3) Approved prescriptions will be filled, and may be picked up at the site designated on the front of the form.

4) The enrolling, or designated follow-up physician will receive an approval letter documenting the status of the prescription, other relevant documents (e.g. treatment history charts, therapy discontinuation alerts), prescription refill forms and a Drug Treatment Program participant (patient) consent form.