



HIV Drug Treatment Program

HIV/AIDS DRUG REQUEST PRESCRIPTION



OFFICE USE ONLY: BC-CfE #

Please return completed form as per instructions on reverse:

By Mail: 687-1081 Burrard Street, Vancouver, BC, V6Z 1Y6 **By Fax:** 604-806-9044, Telephone: 604-806-8515

For new patients, also complete the Drug Treatment Program ENROLMENT form.

Patient and Prescriber Information

Patient: (First or Given Names)	(Last Name)	Telephone:
Patient's Address:	Postal Code	Personal Health Number or Other Billing #

Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Height _____ cm	Date of Birth DD ___ MON ___ YYYY _____
		Weight _____ kg	

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

Prescriber:
Name: _____ MSC number: _____
Address: _____ Telephone: _____
Fax: _____

Follow-up prescriber to order medication refills (if different from the prescriber noted above).

Name: _____ MSC#: _____ Address: _____ Tel: _____

Medical Information

Hepatitis C Antibody Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Most recent bloodwork:	Test Date:
Hepatitis B SAg Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CD4 Absolute Count: _____ DD ___ MON ___ YYYY _____	
History of Injection Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	HIV Plasma Viral Load: _____ DD ___ MON ___ YYYY _____	

Medical History: _____ **Pregnant** **Due Date:** DD ___ MON ___ YYYY _____
Medication Allergy: _____

Medication Regimen: Include Special Access, Expanded Access and Study Medications

<p>New or continuing medication(s) and dosage:</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>6 _____</p> <p>Medication(s) to be discontinued:</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>4 _____</p>	<p><input type="checkbox"/> Continuing meds from outside BC</p> <p><input type="checkbox"/> Re-start after treatment interruption</p> <p>Reason(s) for medication change</p> <p>a) <input type="checkbox"/> Treatment failure (viral load rebound or CD4 decline)</p> <p>b) <input type="checkbox"/> Drug Resistance</p> <p>c) <input type="checkbox"/> Regimen simplification</p> <p>d) <input type="checkbox"/> Drug interaction between _____ & _____</p> <p>e) <input type="checkbox"/> Adverse reaction to _____ (list drugs)</p> <p>Describe reaction/ problem: (include relevant lab test results)</p> <p>reaction onset date: DD ___ MON ___ YYYY _____</p> <p>_____</p> <p>_____</p> <p>Severity: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> potentially life-threatening</p> <p>Hospitalization required: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other possible causes of reaction: _____</p> <p>f) <input type="checkbox"/> Other reason for regimen change: _____</p>
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Prescriber's signature: _____ **MSC#:** _____ **Date:** DD ___ MON ___ YYYY _____

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

How to complete a Prescription Request for HIV medication

In British Columbia, antiretroviral medications and some drugs for HIV care are provided at no cost to qualifying patients through the BC Centre for Excellence in HIV/AIDS (BC-CfE) Drug Treatment Program.

Complete and submit an HIV medication Prescription Request form in the following circumstances:

- New patient, not previously treated in BC. Also submit a completed Drug Treatment Program Enrolment form with the first prescription request.
- Returning to BC-CfE supplied drug after having moved out of BC, received drug from another source (e.g. private insurance, clinical trial), been off therapy, or greater than 6 months overdue for refill.
- Change in HIV drug regimen, including: addition of new drug(s), discontinuation of previous drug(s), dosage changes which affect drug indication (e.g. dose for treatment naive is different than for experienced patients) or product request where a lower cost alternative is available.

The BC-CfE website www.bccfe.ca, “Healthcare Providers” section includes current Therapeutic Guidelines, details about how to obtain HIV medications in BC, medication information pamphlets and more.

For prescribing assistance, **physician consultation (1-800-665-7677)** is available 7 days a week. **Pharmacist consultation (1-888-511-6222)** is available Mon-Fri 8 am-5 pm. After hours, a pharmacist is on call for emergency situations.

1) PRESCRIBER: COMPLETE THE PRESCRIPTION

- Provide complete patient identifier and medication information as required for a legal prescription. Include the most recent HIV plasma viral load and CD4 count and document medication allergies, medical conditions and concurrent medications which could influence the selection or dosage of antiretroviral medication.
- Identify the **follow-up prescriber**: The Physician or Nurse Practitioner who will provide ongoing care and monitoring and authorize prescription refills. Prescription refill forms and other documents will be sent to the requesting prescriber if no follow-up prescriber is specified.
- Specify the authorized prescription pick-up site where the patient will receive the medication (see 3, below).

2) PRESCRIBER: SUBMIT THE PRESCRIPTION FOR BC-CfE AUTHORIZATION

- Keep a copy of the prescription for your records. FAX (preferred) or MAIL prescription request to:
BC-CfE Drug Treatment Program:
Room 687-1081 Burrard Street, Vancouver BC V6Z 1Y6
Telephone: 604-806-8515 Fax: 604-806-9044
- A BC-CfE clinician will review the medication regimen to ensure it is consistent with current Therapeutic Guidelines. The prescriber will be contacted if clarification is required.
- A letter documenting prescription approval will be sent to the prescribing and designated follow-up prescribers.
- When approval notification is received, **it is the responsibility of the prescriber to inform the patient or patient’s care-giver** where to pick up the medication.

3) PATIENT: CONTACT THE PHARMACY TO ARRANGE MEDICATION PICK-UP

It is the responsibility of the patient or care-giver to pick up the medication from the designated location.

A consultation appointment with a pharmacist may be required. Authorized pharmacies include:

St Paul’s Hospital Ambulatory Pharmacy;	163-1081 Burrard St, Vancouver V6Z 1Y6	Tel: 1-888-511-6222
	appointment booking line:	Tel: 604-806-8060
Downtown Clinic Pharmacy;	569 Powell Street, Vancouver V6A 1G8	Tel: 604-216-4257
BC Children’s Hospital Ambulatory Care Pharmacy;	4500 Oak St., Vancouver V6H 3N1	Tel: 604-875-2205
Royal Jubilee Prescriptions;	DT-1200 1952 Bay St., Victoria V8R 1J8	Tel: 250-370-8153
Rexall Drugs #7181;	1750 Dufferin Crescent, Nanaimo V9S 0A4	Tel: 250-753-6655
Lakeside Medicine Centre;	#112A – 2365 Gordon Dr., Kelowna V1W 3C2	Tel: 250-860-3100

HIV medications dispensed at St. Paul’s Hospital Ambulatory Pharmacy may also be delivered to a **community pharmacy, prescriber’s office or other health care facility** for pick-up. Call the St. Paul’s Hospital Outreach Pharmacist (604)-806-8456 for information about how to arrange for prescription delivery to another site.