Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exam Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prophylaxis means disease prevention. HIV Post-Exposure Prophylaxis (nPEP) means taking antiretroviral medications as soon as possible (within 72 hours) after exposure to HIV to reduce the chance of HIV Infection. The treatment period is 28 days with two of the medications noted below.

PATIENT LAB TESTS:

❏ Your rapid HIV test was negative today:

* A negative result means that this test did not detect HIV antibodies in your blood or oral fluid.
* Your body can take several months after you are infected to make the HIV antibodies so it is possible to miss the infection.
* If you were recently infected with HIV, there may not have been enough time to find the HIV in your blood.
* You will need to have further HIV testing over the next 3 months (see below).

ADDITIONAL LAB TESTS PERFORMED TODAY:

❏ HIV Test (4th Generation/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ❏ GC/CT

❏ Pregnancy Test ❏ Syphilis/RPR

❏ CMP ❏ eGFR

❏ Hepatitis B Serology ❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ Hepatitis C Serology ❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ CBC ❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMPORTANT INFORMATION

● You must be under a medical provider’s care while on treatment and for follow up testing.

● You have been referred to (NAME/PHONENUMBER): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

● Schedule an appointment within 3 days of starting the medication. Additionally, inform your medical provider that your pre-treatment labs were drawn at (HOSPITAL/DATE:)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ so they can obtain the results for your first visit.

● During your first visit, your medical provider will discuss dates for follow-up appointments and lab tests.

● Bring all your current medications including over the counter medications, vitamins and supplements. ● Until it has been determined that you have not contracted HIV (3 months), please note the following:

* You should practice safe sex by using condoms;
* Do not share needles, razors or toothbrushes;
* Avoid pregnancy and breastfeeding;
* Refrain from donating blood, plasma, organs, tissue or semen.

● Store all medications at room temperature and keep in a secure container out of the reach of children.

● It is important to take your medications at the times prescribed. Setting a watch or cell phone alarm can remind you to take your medications at a specified time. Contact your medical provider if you miss 24-48 hours of your scheduled medications.

● If you have concerning symptoms including the uncommon side effects listed below, seek medical attention immediately.

YOUR MEDICATIONS

❏TRUVADA (emtricitabine/tenofovir) 200/300mg

● Take 1 pill by mouth, with food, once daily **at the same time every day.**

● IF YOU MISS A DOSE: take it as soon as you remember. However, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule**. Do not double up doses to make up for the missed dose.**

● COMMON SIDE EFFECTS: General feeling of being ill; nausea; headache; depressed mood; mild itching; strange dreams.

● UNCOMMON SIDE EFFECTS THAT REQUIRE YOU TO STOP TAKING THE MEDICATION AND SEEK IMMEDIATE MEDICAL ATTENTION: Shortness of breath, muscle pain, cold feet and/or hands, fast heart rate (signs of lactic acidosis); Yellowing of skin and/or eyes, dark urine, light stools (signs of liver failure); Hives, rash, swelling of face, lips tongue, shortness of breath (allergic reaction).

● TRUVADA CAN CAUSE HARM TO YOUR KIDNEYS: Risk is increased when you also use other medications such as: Advil, Aspirin, Tylenol, Aleve, chemotherapy, antivirals, medicine for bowel disorders, injectable antibiotics and osteoporosis medications.

❏ Your first dose was on (DATE/TIME): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ You were provided a take home pack of Truvada for: \_\_\_\_\_\_\_\_\_\_\_\_\_ days of treatment\_\_\_\_\_\_\_\_\_\_ (total # of pills).

❏ You were given a prescription for Truvada for: \_\_\_\_\_\_\_\_\_\_ days of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_ (total # of pills).

❏ Information on a Pharmaceutical Company Patient Assistance Program has been provided to you that may assist with the cost of this prescription.

❏ Your provider will discuss any other medication assistance programs available in your area.

**AND**

❏ ISENTRESS (raltegravir) 400mg. Take 1 pill by mouth twice a day (every 12 hours), with or without food) **at the same times every day**.

● IF YOU MISS A DOSE: take it as soon as you remember. However, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule**. Do not double up doses to make up for the missed dose.**

● Do not take antacids with Aluminum or Magnesium (Mylanta, Maalox) as it decreases absorption of Isentress.

● COMMON SIDE EFFECTS: General feeling of being ill; nausea; diarrhea; and headache.

● UNCOMMON SIDE EFFECTS THAT REQUIRE YOU TO STOP TAKING THE MEDICATION AND SEEK IMMEDIATE MEDICAL ATTENTION: Severe rash (Stephens-Johnson syndrome); Muscle or joint aches/ pains (rhabdomyolysis); Yellowing of skin and/or eyes, dark urine, light stools (signs of liver failure); Decreased Urine output, lower back pain (kidney Failure); Hives, rash, swelling of face, lips tongue, shortness of breath (allergic reaction).

❏ Your first dose was on (DATE/TIME): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ You were provided with a take home pack of Isentress for: \_\_\_\_\_\_\_\_\_ days of treatment\_\_\_\_\_\_\_\_\_\_ (total # of pills).

❏ You were given a prescription for Isentress for: \_\_\_\_\_\_\_\_\_\_ days of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_ (total # of pills).

❏ Information on a Pharmaceutical Company Patient Assistance Program has been provided to you that may assist with the cost of this prescription.

❏ Your provider will discuss any other medication assistance programs available in your area.

**OR**

❏ TIVICAY (dolutegravir) 50mg. Take one pill by mouth daily (every 24 hours), with or without food**, at the same time every day.**

● IF YOU MISS A DOSE: take it as soon as you remember, however, if it is almost time for the next dose, skip the missed dose and continue your regular dosing schedule**. Do not double up doses to make up for the missed dose.**

● Avoid taking the following medicines within 6 hours before or 2 hours after you take Tivicay: antacids or laxatives that contain calcium, magnesium, or aluminum (such as Amphojel, Di-Gel Maalox, Milk of Magnesia, Mylanta, Pepcid Complete, Rolaids, Rulox, Tums, and others); or the ulcer medicine sucralfate (Carafate); vitamin or mineral supplements that contain calcium or iron as these medications decrease the concentration of Tivicay.

COMMON SIDE EFFECTS: Insomnia; fatigue; and headache.

● UNCOMMON SIDE EFFECTS THAT REQUIRE YOU TO STOP TAKING THE MEDICATION AND SEEK IMMEDIATE MEDICAL ATTENTION: severe rash or rash accompanied by fever, muscle/ joint aches, blisters/peeling of the skin, oral blisters or lesions, conjunctivitis, facial swelling, difficulty breathing (hypersensitivity reaction).

❏ Your first dose was on (DATE/TIME):

❏ You were provided a take home pack of Tivicay for: \_\_\_\_\_\_\_\_\_\_\_\_\_ days of treatment\_\_\_\_\_\_\_\_\_\_ (total # of pills).

❏ You were given a prescription for Tivicay for: \_\_\_\_\_\_\_\_\_\_ days of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_ (total # of pills).

❏ Information on a Pharmaceutical Company Patient Assistance Program has been provided to you that may assist with the cost of this prescription.

❏ Your provider will discuss any other medication assistance programs available in your area.

OPTIONS FOR FOLLOW-UP CARE *(Programs should customize to their location)*

❏ Your Doctor/Clinic/Primary Care Physician

❏ List HIV clinics or providers available in your area*. (It is suggested that the list be periodically checked and updated for accuracy).*

❏ List pharmacies in your area that routinely carry nPEP*. (It is suggested that the list be periodically checked and updated for accuracy).*

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If you have any questions or concerns, please call (NAME/PHONE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PATIENT ACKNOWLEDEMENT

During my evaluation, it was determined that I may have been exposed to the HIV virus. I have consented to and been prescribed a 28-day nPEP medication regimen that may help prevent transmission of the HIV virus.

I have been counseled on taking all of the medications as directed. I was counseled on the need to see a doctor/clinician within three (3) days of my exam. If I do not have a primary physician, I need to contact an infectious disease physician or other medical provider to schedule an appointment.

I will be certain to tell the medical facility with whom I am trying to get an appointment that I may have been exposed to HIV, that I have already started the nPEP medications, and that I need to see a physician within three (3) days of starting this medicine.

I will take a copy of this form along with my other discharge instructions to my medical provider so that they will know what treatment I received and can perform tests to be sure that the medications were effective.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e