PrEPStart Prescription Form

To physicians: Please completely fill out all of the information below to ensure that the patient's prescription can be filled and shipped.

Patient name: _____

Patient address: _____

_____

Patient phone: _____

place patient label here

Gender Identity:

☐ male ☐ female ☐ transman ☐ transwoman

☐ non-binary ☐ other: _____

Patient's date of birth: _____

Date: _____

☐ I have completed an HIV test for the above-named patient which is negative (through Public Health Ontario)

☐ I have completed a creatinine for the above-named patient and the eGFR is greater than 60 mls/min

☐ **YES**. I have counselled the patient on the medication

☐ **NO**. I would like the pharmacist to contact the patient to counsel on the medication

☐ This patient is not already on PrEP and is a new start

RX

Tenofovir/emtricitabine (300/200mg) one tablet po daily

Mitte: 90 day supply

Physician Name:

CPSO Number:

Signature:

Please list any other prescription medications this patient is taking: