

Appendix IV. Pharmacy PrEP prescribing Checklist

Pharmacy: _____ Provider: _____ Qualifications: _____ MFL code: _____

CLIENT PROFILE: Unique client record number: _____ / _____ / _____		Visit date: <i>dd / mm / yyyy</i> Initiating PrEP: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: First _____ Middle _____ Last _____ Telephone no: _____ Alien/National ID/passport/Birth Cert No: _____ Came to pharmacy for: _____		
PrEP initiation ONLY: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of birth: <i>dd / mm / yyyy</i> Age (years): _____ If age <19, attends school: <input type="checkbox"/> Yes <input type="checkbox"/> No Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Married monogamous <input type="checkbox"/> Married polygamous <input type="checkbox"/> Separated/divorced <input type="checkbox"/> Widowed Population type: <input type="checkbox"/> Gen Population <input type="checkbox"/> Discordant couple <input type="checkbox"/> Key Population (Specify) → <input type="checkbox"/> MSM <input type="checkbox"/> MSW <input type="checkbox"/> FSW <input type="checkbox"/> PWID		
[If transferred in:] PrEP start date: <i>dd / mm / yyyy</i> Regimen: <input type="checkbox"/> TDF-FTC <input type="checkbox"/> TDF <input type="checkbox"/> TDF-3TC Facility transferred from: _____ MFL code: _____ County: _____		
PrEP SCREENING:		
Behavioral risk assessment: Mark all that apply (past 6 months)		
Sex partner(s) is HIV+ AND: <i>not on ART, or On ART <6 months, or suspected poor ART adherence, or detectable viral load, or couple trying to conceive</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; border-radius: 15px; padding: 10px; background-color: #f0f0f0;"> <p>At HIV risk; <u>CONTINUE</u> with PrEP initiation at pharmacy</p> </div>
Sex partner(s) high risk & HIV status is unknown:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has sex with >1 partner	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ongoing IPV/GBV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transactional sex	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recent STI (past 6 months)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurrent use of post-exposure prophylaxis (PEP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurrent sex under influence of alcohol/recreational drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Inconsistent or no condom use	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Injection drug use with shared needles and/or syringes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Counseling		
Willing to start/continue PrEP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; border-radius: 15px; padding: 10px; background-color: #f0f0f0;"> <p><u>CONTINUE</u> with PrEP initiation at pharmacy</p> </div>
Adherence counseling Done:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Side effect counseling Done:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family planning counseling Done:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical safety assessment		
Signs & symptoms of acute HIV Infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; border-radius: 15px; padding: 10px; background-color: #f0f0f0;"> <p><u>DO NOT</u> start PrEP; refer to remote clinician</p> </div>
Signs & symptoms of COVID-19 infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver disease:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney disease:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
[If female:] <input type="checkbox"/> Pregnant or <input type="checkbox"/> Breastfeeding:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PrEP refills ONLY:		
Reported PrEP side effects: Describe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; border-radius: 15px; padding: 10px; background-color: #f0f0f0;"> <p><u>DO NOT</u> start PrEP; refer to remote clinician</p> </div>
[if yes:] Side effects severe: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HIV testing		
HIV test result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate [Retest]	<div style="border: 1px solid black; border-radius: 15px; padding: 10px; background-color: #f0f0f0;"> <p><u>DO NOT</u> start PrEP; refer to remote clinician</p> </div>	
[If retest:] HIV test result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate		
PrEP DISPENSING:		
Regimen: <input type="checkbox"/> TDF-FTC <input type="checkbox"/> TDF <input type="checkbox"/> TDF-3TC # of months prescribed: _____	Next appointment date: <i>dd / mm / yyyy</i>	
Date of initiation: <i>dd / mm / yyyy</i>	Provider initials: _____	

