



PREVENTIVE CARE HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) STANDING ORDER AND PROTOCOL for the ILLINOIS PHARMACIST

AUTHORITY and PURPOSE:

Section 43.5 of the Illinois Pharmacy Act provides that “[i]n accordance with a standing order by a physician licensed to practice medicine in all its branches or the medical director of a county or local health department or a standing order by the Department of Public Health, a pharmacist may provide patients with prophylaxis drugs for human immunodeficiency virus pre-exposure prophylaxis or post-exposure prophylaxis.” [225 ILCS 85/43.5](#).

Pharmacists who meet the licensure requirements outlined in Section 6 of the Illinois Pharmacy Practice Act (“Act”) and practice in Illinois and who meet the practice standards outlined in Section 45.3 of the Act may provide the pre-exposure prophylaxis (PrEP) drug regimen according to this standing order. [225 ILCS 85/6](#) and [43.5](#).

The dispensing Pharmacist is responsible for all laboratory tests ordered and resulted, and for reporting as required and outlined in the protocol below. [225 ILCS 85/3\(d\)\(14\)](#).

- All activities under this standing order must be documented and may be subject to audit by the Illinois Department of Public Health or Illinois Department of Financial and Professional Regulation.

PHARMACIST TRAINING/EDUCATION/REPORTING REQUIREMENTS:

- Pharmacists who wish to function under this standing order must complete the following comprehensive training program related to the initiation and dispensing of HIV prevention medications, to include related trauma-informed care, annually: ACPE-accredited training, [HIV Prevention: Pharmacist Provided PrEP and PEP](#) (3 hours). Pharmacists who function under this standing order may be required to produce evidence of the completion of this training on request by IDPH or their licensing body.
- Pharmacists utilizing this standing order are expected to comply with reporting requirements issued by IDPH regarding the utilization of this standing order. Pharmacists will be required to report using the [Pharmacist HIV PrEP Standing Order Quarterly Reporting Form](#).

STANDARDIZED PATIENT ASSESSMENT PROCESS ELEMENTS:

Under this standing order, the licensed pharmacist shall (in the following order)

- Have the patient complete the standardized PrEP Patient Intake Form (Appendix A).
- Proceed to the standardized PrEP Assessment and Treatment Care Pathway (Appendix B).
- Order lab tests as needed. **Note: These tests MUST be ordered under the pharmacist’s NPI and not the NPI of this standing order’s signatory physician.**
- Utilize the standardized PrEP Dispensation Record Template—*optional* (Appendix C).
- Complete and submit the standardized PrEP Primary Care Provider reporting form (Appendix D) when applicable.
- Review reference materials in Appendix E regarding interpretation of lab results and additional requirements to ensure compliance with the protocol (Appendix E).

Sameer Vohra

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Director

License: 036135164
Effective Date: April 22, 2026

NPI Number: 1841585783
Expiration Date: April 21, 2027

REFERENCES AND RESOURCES

- Preexposure Prophylaxis for the Prevention of HIV Infection in the United States—2021 Update. <https://stacks.cdc.gov/view/cdc/112360>.
- CDC. Preventing HIV with PrEP. <https://www.cdc.gov/hiv/prevention/prep.html>.
- National Clinical Consultant HIV Warmline 844-ASK NCCC (844-275-6222)
- Prep4IL website and hotline: Prep4illinois.com, 1-833-773-7445 (1-833-PREP4IL)
- IL HIV/AIDS Hotline 800-243-2437 for referral resources.

Oral Pre-Exposure Prophylaxis (PrEP) for HIV: Standing Order

(CONFIDENTIAL-Protected Health Information)

Appendix A: HIV PrEP Patient Intake Form

*Note: This service must be provided in a private and confidential manner.

Patient Information

Date ____/____/____

Date of Birth ____/____/____ Age ____

Name on Documents _____

Name _____

Sex Assigned at Birth (circle) M / F / Intersex Gender: _____

Are you transgender? (circle) Y/N _____

Pronouns: She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, _____

Street Address _____

Phone () _____

Email Address _____

Primary or HIV PrEP Healthcare Provider
Name _____

Phone () _____ Fax () _____

If no primary care provider, are you interested in a getting
set up for one? Yes/No

Local FQHCs are listed under
<https://findahealthcenter.hrsa.gov>



Free and Charitable Clinics are listed under
<https://www.illinoisfreeclinics.org/clinic-search>



Do you have health insurance? Yes / No
If yes, please see resources given by your pharmacist as
well as the following.

Insurance Provider Name _____

If no insurance, please ask about the drug company
patient assistance program or Prep4IL program for
free/low-cost options:

www.prep4illinois.com



Any allergies to medications? Yes / No

If yes, please list _____

Oral Pre-Exposure Prophylaxis (PrEP) for HIV: Standing Order

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Appendix A: HIV PrEP Patient Intake Form

Background Information: These questions are highly confidential and help the pharmacist to determine if ORAL PrEP may benefit you, be safe for you, and what lab screenings are recommended before starting or continuing PrEP.

Section 1: Reason for HIV Pre-Exposure Prophylaxis (PrEP) and Eligibility

Please review and answer questions 1a, 1b and 1c at the bottom of this box:	
<ul style="list-style-type: none">▪ I want to start PrEP.▪ I want to keep taking PrEP.▪ I had sex in the past 6 months.▪ I do not always use condoms when I have sex.▪ I had gonorrhea, chlamydia, or syphilis in the past 6 months.	<ul style="list-style-type: none">▪ I had sex with someone living with HIV.▪ I had sex with one or more partners and did not know their HIV status.▪ I injected drugs in the past 6 months.▪ I shared injection equipment (any).
1a. Is your answer YES to any of the above statements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
1b. Are you UNDER 18 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1c. Do you weigh LESS than 77 pounds (35 kg)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2: HIV Testing, PrEP, and HIV Post-Exposure Prophylaxis (PEP) Histories; Acute HIV Symptom Review

2a. Have you ever had a positive, reactive, detected, or indeterminate or “neither positive or negative” or “unclear” test for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2b. Have you had any of the following in the last 4 weeks: fever, feeling very tired, muscle or joint aches or pain, rash, sore throat, headache, night sweats, swollen lymph nodes, diarrhea, or general flu-like symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2c. Are you taking PrEP now or have you taken PrEP in the past? <ul style="list-style-type: none">• If now, which PrEP medicine? _____ . Skip question 2d and continue to question 2e.• If in the past, what was your reason for stopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2d. Are you currently finishing a 4-week course of HIV PEP after a possible HIV exposure? (Please note, this is not Doxy PEP which you may also be on.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2e. When was your last unprotected sex, injection drug use, or other possible exposure to HIV?	<input type="checkbox"/> Less than 72 hours (3 days) ago <input type="checkbox"/> More than 72 hours (3 days), but less than 4 weeks ago <input type="checkbox"/> More than 4 weeks ago

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Appendix A: HIV PrEP Patient Intake Form

Section 3: Brief Medical History to Determine Which PrEP Medication May Be Best for You

3a. Have you been told you have kidney disease (e.g., kidney failure, poor kidney function)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3b. Have you been told you have a bone disease (e.g., osteoporosis, osteopenia, low bone mineral density, "weak bones", etc.?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3c. Have you ever had Hepatitis B infection? -- Have you been vaccinated for Hepatitis B? If Yes, Date(s): #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ If No: Do you want to start the hepatitis B vaccination today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Yes <input type="checkbox"/> No
3d. Are you pregnant, breastfeeding or planning to become pregnant? --If no, do you use any methods to prevent pregnancy? Please list: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply
3e. Please list the names of other prescriptions (medicines), over-the-counter, herbal, or supplement products that you take so that the pharmacist can check for drug interactions with PrEP. Please note doses and use of any non-steroidal anti-inflammatory medicines (NSAIDs: ibuprofen (Advil/Motrin), naproxen (Aleve), meloxicam, celecoxib, diclofenac) and any estradiol containing gender-affirming hormone medicines. _____ _____ _____ _____ _____	
3f. Please list any other questions or medical concerns you would like the pharmacist to know: 	

Section 4: What to Expect on Oral PrEP

The biggest risks of PrEP are:

1. Starting PrEP when you may already have HIV; **and**
2. Staying on PrEP instead of treatment after getting HIV. PrEP medicines are also used to treat HIV, but it's not full treatment. If someone starts the PrEP medicine while living with HIV *-or-* contracts HIV while taking PrEP, then the medicines in PrEP might not work as well as they need to for treatment.

Please be aware that:

1. HIV testing should be done every 3 months while taking PrEP. The pharmacist must document a negative HIV test result within the last 7 days before prescribing PrEP. If that is the only lab result available, then the pharmacist can only prescribe up to a 30-day supply until other labs are done. When all needed lab results are given to the pharmacist, then the pharmacist may be able to prescribe up to a 90-day supply each time.
2. Screenings for gonorrhea, chlamydia, and syphilis must be done at least every 6 months while taking PrEP. Undiagnosed sexually transmitted infections (STIs) may increase the risk of contracting HIV, even while you are taking PrEP, and PrEP does NOT protect against other STIs. Screening for gonorrhea and chlamydia must be done at each possible site of exposure via urine (genital) and swab (throat and rectum) collections. You will be asked to submit your test results to the pharmacist to ensure that you are getting all the care you need.
3. Missing doses of PrEP increases the risk of contracting HIV. PrEP works the best when taken AS DIRECTED by the pharmacist. Please talk to your pharmacist if you are having trouble taking your PrEP and/or getting labs done.

Patient Signature: _____ Date: _____

Oral Pre-Exposure Prophylaxis (PrEP) for HIV: Standing Order

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Appendix B: HIV ORAL Pre-Exposure Prophylaxis (PrEP) Assessment & Treatment Care Pathway

7) RECOMMENDED REGIMENS

Note: There are other FDA-Approved medications available and there may be other dosing strategies for PrEP. Daily dosing of emtricitabine / tenofovir DF and emtricitabine / tenofovir alafenamide are the only regimens permitted for pharmacist prescribing at this time.

Emtricitabine/Tenofovir disoproxil fumarate (F/TDF or TDF/FTC)

Dose: 200/300 mg once daily

FDA-Approved for: all HIV exposure risk indications.

Preferred if: pregnancy/breastfeeding, vaginal exposure risks, substance use risks.

Not preferred if: concomitant nephrotoxic medications, or risks for/known renal insufficiency or osteopenia/osteoporosis.

Cost: available as a generic, lower-cost option.

Emtricitabine/Tenofovir alafenamide (F/TAF or TAF/FTC)

Dose: 200/25 mg once daily

FDA-Approved for: use by natal males and transgender women only.

Not approved for: natal females with HIV risk via vaginal sex or any persons, regardless of gender, if injection substance use is the only HIV risk.

Preferred if: renal insufficiency, risk of renal insufficiency (e.g. uncontrolled hypertension or uncontrolled blood glucose), and/or bone density concerns for men or transgender women ONLY.

Cost: no generic, may require prior authorization, patient may be eligible for manufacturer assistance program -or- copay card.

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Appendix B: HIV ORAL Pre-Exposure Prophylaxis (PrEP) Assessment & Treatment Care Pathway

REQUIRED PrEP INITIATION LABORATORY TESTS—Required Baseline Labs	
<p>HIV</p> <ul style="list-style-type: none"> - Must have negative HIV Ag/Ab test within the past 7 days prior to dispensing PrEP. HIV Ag/Ab test: <input type="checkbox"/> non-reactive HIV RNA test (optional but preferred at initiation): <input type="checkbox"/> not detected OK to proceed. 	<ul style="list-style-type: none"> <input type="checkbox"/> HIV Ag/Ab test result reactive or indeterminate. <input type="checkbox"/> HIV RNA test result detected or indeterminate. <p style="text-align: right;">Refer immediately to an HIV care provider and report to local health department ^{1,2}</p>
<p>Hepatitis B Status</p> <ul style="list-style-type: none"> - Order hepatitis B surface antigen, surface antibody, and total core antibody. - Counsel about the risk of hepatitis B flare if PrEP is stopped while living with an unknown or known current hepatitis B infection. - Do not start PrEP if the patient has current hepatitis B infection. Refer to their treating clinical provider. - See https://www.cdc.gov/hepatitis-b/hcp/diagnosis-testing/?CDC_AAref_Val=https://www.cdc.gov/hepatitis/hbv/interpretationOfHepBSerologicResults.htm for further information on hepatitis B test result interpretation. 	
<ul style="list-style-type: none"> <input type="checkbox"/> all non-reactive <input type="checkbox"/> surface antiGEN negative, core antibody negative, surface antibody positive/reactive (indicative of prior vaccination) <input type="checkbox"/> surface antiGEN negative with reactive/positive surface antibody and reactive/positive total core antibody (indicative of prior infection) OK to proceed. 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive, positive, or indeterminate surface antiGEN (with any combination of results for surface antiBODY and total core antibody) indicates possible current hepatitis B infection. <input type="checkbox"/> only total core antibody reactive or positive <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>Renal Function Status</p> <p>Order lab at intake and annually thereafter. If ≥ 50 yrs old -or- eCrCl < 90 ml/min at PrEP initiation, order every 6 months.</p>	
<ul style="list-style-type: none"> <input type="checkbox"/> CrCl ≥ 60 mL/min <p>OK to proceed.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> CrCl is < 60 ml/min, do NOT use F/TDF Consider F/TAF in cis-gender men and TGW with risk factors for kidney disease with a CrCl>30mL/min, but less than 60mL/min. <input type="checkbox"/> CrCl is < 60 ml/min AND not a candidate for F/TAF (i.e., vaginal sex is an HIV exposure risk) * -or- <input type="checkbox"/> CrCL is < 30 ml/min* • If yes to either, refer to treating clinical provider. • Pharmacist prescribing of PrEP is contraindicated for patients who are under the care of a specialist for chronic kidney disease.
<p>Syphilis/Treponemal Antibody</p> <ul style="list-style-type: none"> - Order lab at initial intake and every 90-180 days depending on risk. Non-treponemal test (such as RPR or VDRL) with reflex to treponemal test (such as FTA- ABS, TP-PA, EIA, CIA) -or- treponemal test with reflex to non-treponemal test. <input type="checkbox"/> non-reactive 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive or indeterminate <p>Pharmacist may proceed with prescribing PrEP but should communicate results and refer/report as below. (see Appendix E, Communication Example D).</p> <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>Gonorrhea and Chlamydia Screenings</p> <ul style="list-style-type: none"> - Order lab at initial intake and every 90-180 days depending on risk. - Patients can determine which sites need to be screened. Urinalysis test result: <input type="checkbox"/> non-reactive Pharyngeal test result: <input type="checkbox"/> non-reactive Rectal test result: <input type="checkbox"/> non-reactive 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive or indeterminate test from any site <p>Pharmacist may proceed with prescribing PrEP (see Appendix E, Communication Example D).</p> <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>Hepatitis C Ab—Required for Some</p> <p>Recommended for:</p> <ul style="list-style-type: none"> - MSM minimum annually - TGW minimum annually - PWID every 3 to 6 months <input type="checkbox"/> non-reactive 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive, positive, detected, or indeterminate <p>Pharmacist may proceed with prescribing PrEP.</p> <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>HCG Pregnancy Test—Optional</p> <ul style="list-style-type: none"> - Recommended for: Persons who may become pregnant - Frequency: Every 3 to 12 months per patient preference and pharmacist clinical judgment <input type="checkbox"/> negative 	<ul style="list-style-type: none"> <input type="checkbox"/> Positive <p>Pharmacist may proceed with prescribing PrEP.</p> <p style="text-align: right;">Refer to treating clinical provider</p>

MSM = men who have sex with men; TGW = transgender women; PWID = people who inject drugs

¹ Lab Reporting: The IDPH [disease reporting poster](#) for clinicians summarizes reporting timeframe rules and lists the diagnoses for which lab-confirmed and clinically suspect cases must be reported to the local health department.

² Local Health Department Directory: <https://dph.illinois.gov/about/lhd.html>

Oral Pre-Exposure Prophylaxis (PrEP) for HIV: Standing Order

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Appendix B: HIV ORAL Pre-Exposure Prophylaxis (PrEP) Assessment & Treatment Care Pathway

REQUIRED PrEP CONTINUATION LABORATORY TESTS	
<p>HIV</p> <ul style="list-style-type: none"> - Must have negative HIV Ag/Ab test within the past 7 days prior to dispensing PrEP. HIV Ag/Ab test: <input type="checkbox"/> non-reactive HIV RNA test (optional but preferred at initiation): <ul style="list-style-type: none"> <input type="checkbox"/> detected <input type="checkbox"/> indeterminate <input type="checkbox"/> not detected 	<ul style="list-style-type: none"> <input type="checkbox"/> HIV Ag/Ab test result reactive or indeterminate. <input type="checkbox"/> HIV RNA test result detected or indeterminate. <p style="text-align: right;">Refer immediately to HIV care provider and report to local health department ^{1,2}</p>
<p>Renal Function Status</p> <p>Order lab at intake and annually thereafter. If ≥ 50 yrs old -or- eCrCl < 90 ml/min at PrEP initiation, order every 6 months.</p>	
<ul style="list-style-type: none"> <input type="checkbox"/> CrCl ≥ 60 mL/min <input type="checkbox"/> CrCl 30-59 mL/min <input type="checkbox"/> CrCl < 30 mL/min 	<ul style="list-style-type: none"> <input type="checkbox"/> CrCl is < 60 ml/min, do NOT use F/TDF Consider F/TAF in cis-gender men and TGW with risk factors for kidney disease with a CrCl >30mL/min, but less than 60mL/min. <input type="checkbox"/> CrCl is < 60 ml/min AND not a candidate for F/TAF (i.e., vaginal sex is an HIV exposure risk) -or- <input type="checkbox"/> CrCL is < 30 ml/min • If yes to either, refer to treating clinical provider. • Pharmacist prescribing of PrEP is contraindicated for patients who are under the care of a specialist for chronic kidney disease.
<p>Syphilis/Treponemal Antibody</p> <ul style="list-style-type: none"> - Order lab at initial intake and every 90-180 days depending on risk. Non-treponemal test (such as RPR or VDRL) with reflex to treponemal test (such as FTA- ABS, TP-PA, EIA, CIA) -or- treponemal test with reflex to non-treponemal test. <input type="checkbox"/> non-reactive 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive or indeterminate Pharmacist may proceed with prescribing PrEP (see Appendix E, Communication Example D) <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>Gonorrhea and Chlamydia Screenings</p> <ul style="list-style-type: none"> - Order lab at initial intake and every 90-180 days depending on risk. - Patients can determine which sites need to be screened. Urinalysis result: <input type="checkbox"/> non-reactive Pharyngeal test result: <input type="checkbox"/> non-reactive Rectal test result: <input type="checkbox"/> non-reactive 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive or indeterminate test from any site Pharmacist may proceed with prescribing PrEP (see Appendix E, Communication Example D.) <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>Hepatitis C Antibody—Required for Some</p> <p>Recommended for:</p> <ul style="list-style-type: none"> - MSM minimum annually - TGW minimum annually - PWID every 3 to 6 months <input type="checkbox"/> non-reactive 	<ul style="list-style-type: none"> <input type="checkbox"/> reactive, positive, detected, or indeterminate Pharmacist may proceed with prescribing PrEP. <p style="text-align: right;">Refer to treating clinical provider and report to local health department ^{1,2}</p>
<p>HCG Pregnancy Test—Optional</p> <ul style="list-style-type: none"> - Recommended for: Persons who may become pregnant - Frequency: Every 3 to 12 months per patient preference and pharmacist clinical judgment <input type="checkbox"/> negative 	<ul style="list-style-type: none"> <input type="checkbox"/> Positive Pharmacist may proceed with prescribing PrEP. <p style="text-align: right;">Refer to treating clinical provider</p>

MSM = men who have sex with men; TGW = transgender women; PWID = people who inject drugs

¹ Lab Reporting: The IDPH [disease reporting poster](#) for clinicians summarizes reporting timeframe rules and lists the diagnoses for which lab-confirmed and clinically suspect cases **must be reported** to the local health department.

² Local Health Department Directory: <https://dph.illinois.gov/about/lhd.html>

Appendix C: IDPH Standing Order PrEP Dispensation Record

Optional: May be used by pharmacy if desired.



Patient Name:	Date of Birth:
Address:	
City/State/Zip Code:	Phone Number:

Note: Pharmacist may not dispense and must refer patient if HIV test is reactive or indeterminate or if injectable PrEP is deemed most appropriate.

Rx

- emtricitabine/tenofovir disoproxil fumarate 200/300mg tablets**
 - Take one tablet by mouth daily for 30 days, #30, 0 refills
 - Take one tablet by mouth daily for 90 days, #90, 0 refills

-or-

- emtricitabine/tenofovir alafenamide 200/25mg tablets**
 - Take one tablet by mouth daily for 30 days, #30, 0 refills
 - Take one tablet by mouth daily for 90 days, #90, 0 refills

Dispensed Date: _____

Expiration Date: (Expires 90 days from the written date) _____

Pharmacist Name: _____ Pharmacist Signature: _____

Pharmacy Address: _____ Pharmacy Phone: _____

-or-

- Patient Referred
- Hepatitis B Vaccine administered:
Lot: _____ Expiration Date: _____ Dose: _____ of 2 or 3 (circle one)

Notes: _____

PrEP4IL application needed: Yes/No

Website: Prep4illinois.com

Helpline: 1-833-773-7445 (1-833-PREP4IL)

Manufacturer Copay Card Information:

RXBIN:	RXPCN:	GROUP:
ISSUER:	ID:	

Appendix D: Primary Care Provider Notification Form

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Dear Provider _____ (name) (____) ____ - _____ (FAX)

Your patient _____ (name) ____/____/____ (DOB) has been dispensed HIV Pre-Exposure Prophylaxis (PrEP) by _____, RPH. This regimen was filled on ____/____/____ (Date) for a ____ day supply and follow-up HIV testing is recommended in approximately ____ days ____/____/____ (Date)

This regimen consists of the following (check one):

- | | |
|--|---|
| <input type="checkbox"/> emtricitabine/tenofovir disoproxil fumarate 200/300mg tablets
<ul style="list-style-type: none"> • Take one tablet by mouth daily | <input type="checkbox"/> emtricitabine/tenofovir alafenamide 200/25mg tablets
<ul style="list-style-type: none"> • Take one tablet by mouth daily |
|--|---|

Your patient has been tested for and/or indicated the following :

Test Name	Date of Test	Result	Needs referral
• HIV ag/ab (4th gen):	____/____/____	<input type="checkbox"/> reactive <input type="checkbox"/> indeterminate <input type="checkbox"/> non-reactive	<input type="checkbox"/> Yes
• HIV RNA:	____/____/____	<input type="checkbox"/> detected <input type="checkbox"/> indeterminate <input type="checkbox"/> not detected	<input type="checkbox"/> Yes
• Hepatitis B surface antigen:	____/____/____	<input type="checkbox"/> reactive <input type="checkbox"/> non-reactive	<input type="checkbox"/> Yes
• Hepatitis C antibody:	____/____/____	<input type="checkbox"/> reactive <input type="checkbox"/> non-reactive	<input type="checkbox"/> Yes
• Syphilis/Treponemal antibody:	____/____/____	<input type="checkbox"/> reactive <input type="checkbox"/> indeterminate <input type="checkbox"/> non-reactive	<input type="checkbox"/> Yes
• Gonorrhea/Chlamydia:	____/____/____		<input type="checkbox"/> Yes
Urinalysis result:	Pharyngeal test result:	Rectal test result:	
<input type="checkbox"/> reactive <input type="checkbox"/> indeterminate	<input type="checkbox"/> reactive <input type="checkbox"/> indeterminate	<input type="checkbox"/> reactive <input type="checkbox"/> indeterminate	
<input type="checkbox"/> non-reactive	<input type="checkbox"/> non-reactive	<input type="checkbox"/> non-reactive	
• Renal function (CrCl):	____/____/____	_____ mL/min	<input type="checkbox"/> Yes
<input type="checkbox"/> CrCl >60mL/min	<input type="checkbox"/> CrCl 30mL/min - 60mL/min	<input type="checkbox"/> CrCl <30mL/min	
• HCG:	____/____/____	<input type="checkbox"/> positive <input type="checkbox"/> indeterminate <input type="checkbox"/> negative	<input type="checkbox"/> Yes
• Signs/symptoms of acute retroviral syndrome (<input type="checkbox"/> Present <input type="checkbox"/> Not Present) AND potential HIV exposure in the last 4 weeks (<input type="checkbox"/> Yes <input type="checkbox"/> No) AND not on PrEP (<input type="checkbox"/> Yes <input type="checkbox"/> No).			<input type="checkbox"/> Yes
• Exposure risk less than 72 hours ago? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes

We recommend evaluating the patient, confirming the results, and treating as necessary. *Listed below are some key points to know about PrEP.*

Primary Care Provider information on pharmacist-initiated HIV PrEP:

- PrEP is prescribed for up to a 90-day supply for each prescription to align with appropriate lab monitoring guidelines.
- TDF/FTC is not recommended for CrCl less than 60 mL/min. Please contact the pharmacy if this applies to your patient and/or there is a decline in renal function. TAF/FTC may be a better option.
- TDF/FTC and TAF/FTC are both safe in pregnancy. If your patient is pregnant or becomes pregnant, they may continue PrEP.
- Regular NSAID use should be avoided while patients are taking HIV PrEP to avoid drug-drug interactions with TDF/FTC.
- TDF/FTC is a first line option for hepatitis B treatment. This is not a contraindication to PrEP use, but we recommend you refer hepatitis B positive patients to an infectious disease or gastroenterology specialist to help manage PrEP. PrEP will not be initiated by a pharmacist for these patients.
- A positive STI test is not a contraindication for PrEP.

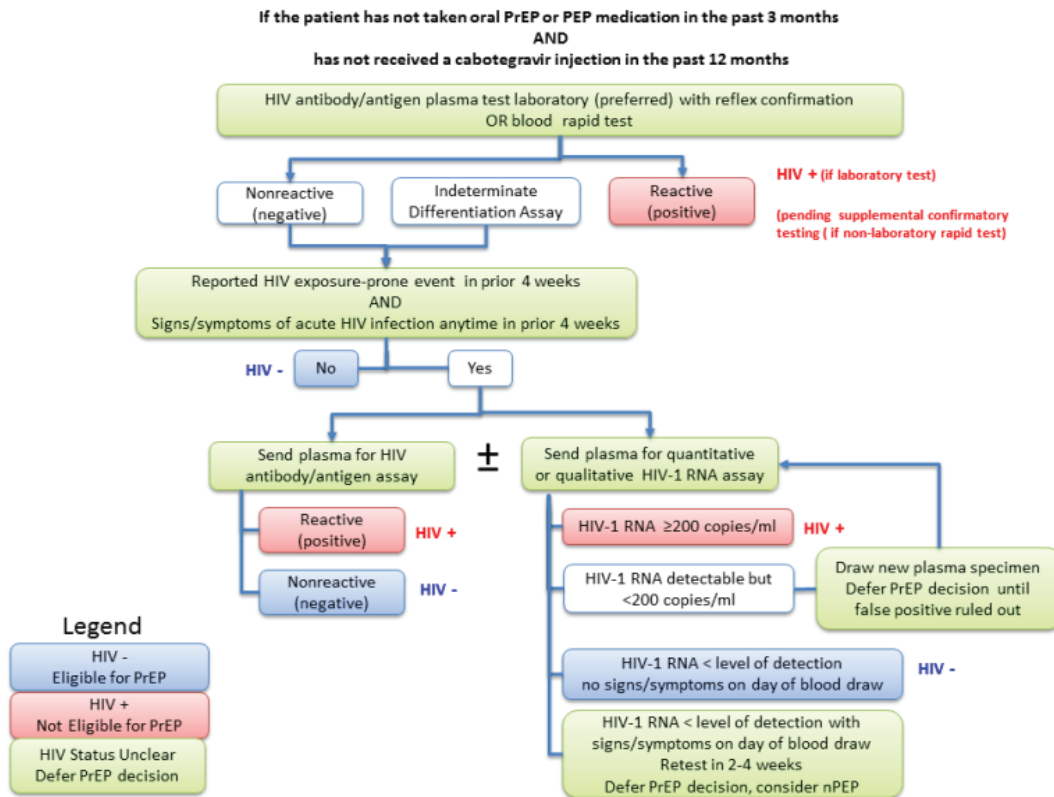
Pharmacist monitoring of HIV PrEP and transition of care:

- The pharmacist dispensing PrEP under a standing order conducts and/or reviews results of HIV testing, STI testing, and other baseline and treatment monitoring lab results as part of their patient assessment.
- Patients who test reactive or indeterminate for HIV, gonorrhea/chlamydia, syphilis, or hepatitis B will be referred to your office for evaluation, diagnosis, and treatment.
- Your office may take over management of this patient's HIV PrEP from the pharmacy at any time.

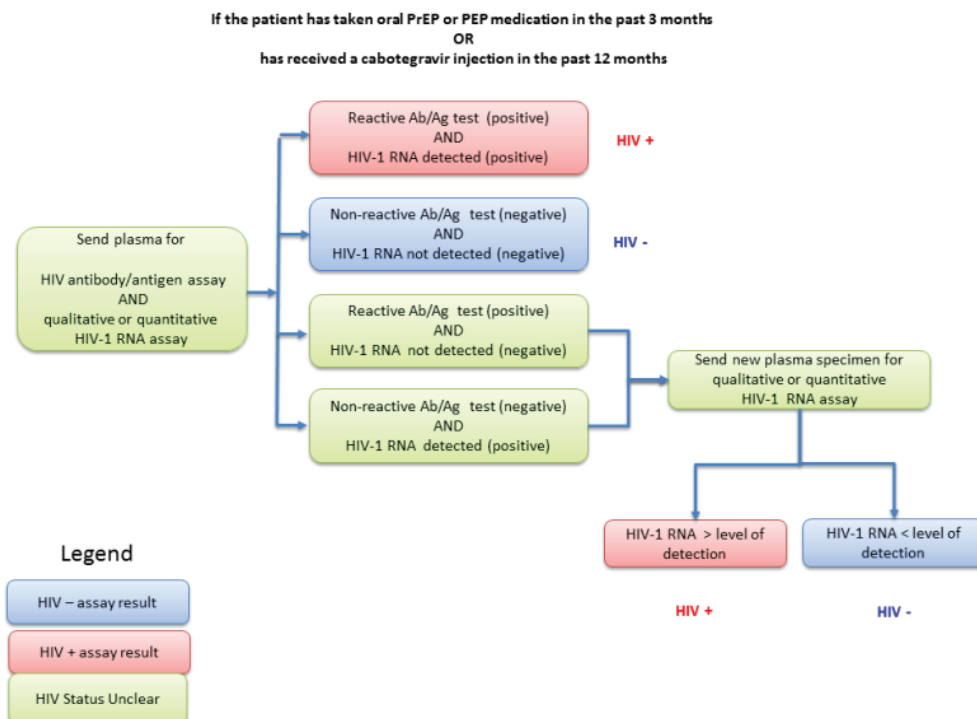
If you have additional questions, please contact the dispensing pharmacy, or call the HIV Warmline. The National HIV Warmline offers consultations for providers from HIV specialists and is available every day at: (855) 448-7737. For information about PrEP, please visit the [IDPH](#) website.

Appendix E: Reference Materials to Ensure Compliance with Protocol

Clinician Determination of HIV Status for PrEP Provision to Persons without Recent Antiretroviral Prophylaxis Use



Clinician Determination of HIV Status for PrEP Provision to Persons with Recent Antiretroviral Prophylaxis Use



Appendix E: Reference Materials to Ensure Compliance with Protocol

ORAL PrEP LABORATORY REQUIREMENTS

Table 1a: Summary of Clinician Guidance for Daily Oral PrEP Use

	Sexually-Active Adults and Adolescents ¹	Persons Who Inject Drug ²
Identifying substantial risk of acquiring HIV infection	Anal or vaginal sex in past 6 months AND any of the following: <ul style="list-style-type: none"> • HIV-positive sexual partner (especially if partner has an unknown or detectable viral load) • Bacterial STI in past 6 months³ • History of inconsistent or no condom use with sexual partner(s) 	HIV-positive injecting partner OR Sharing injection equipment
Clinically eligible	ALL OF THE FOLLOWING CONDITIONS ARE MET:	
	<ul style="list-style-type: none"> • Documented negative HIV Ag/Ab test result within 1 week before initially prescribing PrEP • No signs/symptoms of acute HIV infection • Estimated creatinine clearance ≥ 30 ml/min⁴ • No contraindicated medications 	
Dosage	<ul style="list-style-type: none"> • Daily, continuing, oral doses of F/TDF (Truvada®), ≤ 90-day supply OR • For men and transgender women at risk for sexual acquisition of HIV; daily, continuing, oral doses of F/TAF (Descovy®), ≤ 90-day supply 	
Follow-up care	<p>Follow-up visits at least every 3 months to provide the following:</p> <ul style="list-style-type: none"> • HIV Ag/Ab test and HIV-1 RNA assay, medication adherence and behavioral risk reduction support • Bacterial STI screening for MSM and transgender women who have sex with men³ – oral, rectal, urine, blood • Access to clean needles/syringes and drug treatment services for PWID <p>Follow-up visits every 6 months to provide the following:</p> <ul style="list-style-type: none"> • Assess renal function for patients aged ≥ 50 years or who have an eCrCl < 90 ml/min at PrEP initiation • Bacterial STI screening for all sexually-active patients³ – [vaginal, oral, rectal, urine- as indicated], blood <p>Follow-up visits every 12 months to provide the following:</p> <ul style="list-style-type: none"> • Assess renal function for all patients • Chlamydia screening for heterosexually active women and men – vaginal, urine • For patients on F/TAF, assess weight, triglyceride and cholesterol levels 	

¹ adolescents weighing at least 35 kg (77 lb)

² Because most PWID are also sexually active, they should be assessed for sexual risk and provided the option of CAB for PrEP when indicated

³ Sexually transmitted infection (STI): Gonorrhea, chlamydia, and syphilis for MSM and transgender women who have sex with men including those who inject drugs; Gonorrhea and syphilis for heterosexual women and men including persons who inject drugs

⁴ estimated creatine clearance (eCrCl) by Cockcroft Gault formula ≥ 60 ml/min for F/TDF use, ≥ 30 ml/min for F/TAF use

Test	Screening/Baseline Visit	Q 3 months	Q 6 months	Q 12 months	When stopping PrEP
HIV Test	X*	X			X*
eCrCl	X		If age ≥ 50 or eCrCl < 90 ml/min at PrEP initiation	If age < 50 and eCrCl ≥ 90 ml/min at PrEP initiation	X
Syphilis	X	MSM /TGW	X		MSM/TGW
Gonorrhea	X	MSM /TGW	X		MSM /TGW
Chlamydia	X	MSM /TGW	X		MSM /TGW
Lipid panel (F/TAF)	X			X	
Hep B serology	X				
Hep C serology	MSM, TGW, and PWID only			MSM, TGW, and PWID only	

* Assess for acute HIV infection (see Figure 4)

MSM = men who have sex with men; TGW = transgender women; PWID = People who inject drugs

HIV RNA test is highly recommended at baseline if symptoms of possible acute retroviral syndrome are present or develop while taking PrEP. It is recommended every 3 months as part of PrEP monitoring; however, it is not a required test and should not be a barrier to prescribing PrEP.

Appendix E: Reference Materials to Ensure Compliance with Protocol

COMMUNICATION EXAMPLES

<p>Example A Reactive, positive, indeterminate, -or- detected result for:</p> <p>HIV Ag/Ab -or- HIV RNA</p>	<p>Your HIV test is [reactive, positive, -or- indeterminate]. This may mean you have HIV infection, but you do need further testing to confirm if this is a true result. Would you prefer to go to your primary care provider, an emergency department or urgent care clinic, local health department, or an HIV specialist for further evaluation? It is important that you STOP taking PrEP now as it is an incomplete treatment for HIV and can lead to drug resistance in the future. Until you know your confirmed HIV test results/status after that additional testing, please use condoms during sex. Use sterile injection equipment. Do not share with others. You may start PrEP again with a PrEP provider if it is determined that this was a false result and you do NOT have an HIV infection. I can help you make an appointment for further evaluation if you would like.</p>
<p>Example B Concerns for acute HIV infection NOT on PrEP</p>	<p>Based on the [symptoms AND last possible exposure to HIV] that you reported, there is a chance that this is a sign of a recent HIV infection. These symptoms are also general and could be related to the flu, or another viral illness. You would need testing that looks directly for the virus before we can START PrEP. I cannot prescribe PrEP today, but we can get you started once we have these other lab results.</p> <p>You should see your primary care provider or an emergency department/urgent care clinic for evaluation, possible other viral illness testing, and follow-up of your symptoms. They could also start you on PrEP if they decide it's appropriate to start now. Please let me know if you want a referral and/or would like me to refer you to a community organization¹ that can help link you to care and evaluation.</p>
<p>Example C Concerns for acute HIV infection ON PrEP</p>	<p>Based on the [symptoms AND last possible exposure to HIV] that you reported, there is a chance that this is a sign of recent HIV infection. These symptoms are also very general and could be related to the flu, or another viral illness. You would need another test that looks directly for the virus. These should be done at 2 to 4 weeks after your possible exposure to HIV. While we wait for those lab results, I can prescribe up to a 30-day supply for this refill.</p> <p>You should see your primary care provider, clinic-based PrEP provider, or urgent care clinic for evaluation, possible other viral illness testing, and follow-up of your symptoms. Please let me know if you want a referral and/or would like me to refer you to a community organization¹ that can help link you to care and evaluation.</p>
<p>Example D Substantial risk for HIV acquisition within the past 72 hours</p>	<p>Based on your last possible exposure to HIV, you should be evaluated to start post-exposure prophylaxis or PEP to prevent HIV infection. You would need to take PEP for 28 hours and get re-tested for HIV afterwards. If you remain negative, you can start PrEP immediately after completing your 28 days of PEP.</p> <p>You should see your primary care provider, an urgent care clinic, or an emergency department right away as you need to start PEP within 72 hours of exposure. Please let me know if you want a referral or need assistance with this.</p>
<p>Example E Reactive, positive, -or- indeterminate result for:</p> <p>Gonorrhea -or- Chlamydia -or- Syphilis (if tested at the pharmacy)</p>	<p>There were [reactive, positive, -or- indeterminate] results for [gonorrhea, chlamydia, and/or syphilis]. You may need further evaluation by a medical provider. Please keep taking your PrEP, do not stop PrEP. Please use condoms during sexual activity until you have been evaluated and/or treated by a medical provider. I can help you make an appointment for further evaluation/treatment with a primary care provider, urgent care clinic, or local health department or sexual health clinic if needed.</p>

¹Call 800-243-2437 IL HIV/AIDS Hotline if assistance is needed.