

HIV POST EXPOSURE PROPHYLAXIS INSTRUCTIONS

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 below medications

IMPORTANT INFORMATION

- You must be under a medical provider's care both while on treatment and for follow up testing.
- You have been referred (NAME/PHONENUMBER): _____.
- Schedule an appointment for 3-5 days after starting medication. Additionally, inform them your pre-treatment labs were drawn at (HOSPITAL/DATE:) _____ so they can obtain the results for your 1st visit.
- You will have future lab draws and appointments. The scheduling of both will be arranged at your first appointment.
- Bring all your current medications including over the counter medications, vitamins and supplements.
- Until it has been determined that you have not contracted HIV (6mos) you should practice safe sex (condoms), do not share needles, razors or toothbrushes.
- Store both medications at room temperature. Keep both medications in a secure container and out of reach of children
- It's important you take your medications at the times as prescribed. Set a watch or cell phone alarm for times to take your HIV-1 medicines.
- **If you have concerning symptoms including the uncommon Side Effects listed below, Seek immediate medical attention.**

YOUR MEDICATIONS

TRUVADA (emtricitabine/tenofovir) 200/300mg, Take 1 pill by mouth once daily. 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 missed dose.
- COMMON SIDE EFFECTS: General feeling of being ill, nausea, headache, depressed mood, mild itching and strange dreams
- UNCOMMON SIDE EFFECTS THAT REQUIRE YOU 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: Advil, Aspirin, Tylenol, Aleve, chemotherapy, antivirals, medicine for bowel disorders, injectable antibiotics and osteoporosis medications.
- 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).
- A Patient Assistance Form has been submitted on your behalf to cover the cost of this prescription. Once approved we will contact you with the necessary information to take to the pharmacy along with your prescription. It will be filled at no cost to you.
- You have been provided a co-pay assistance card. Take this card and your prescription to the pharmacy. The card will cover all co-pay costs.

Your first Dose was on (DATE/TIME): _____

AND

ISENTRISS (raltegravir) 400mg. Take 1 pill by mouth twice a day (every 12 hours). 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 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 STOP TAKING THE MEDICATION AND SEEK IMMEDIATE MEDICAL ATTENTION: Severe rash (Stevens-Johnson syndrome), Muscle or joint aches/ pains (rhabdomyolysis). Yellowing of skin and/or yes, 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)
- You were provided 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).
- A Patient Assistance Form has been submitted on your behalf to cover the cost of this prescription or co-pay. Once approved we will contact you with the scheduled date of delivery. Someone must be home to receive the package.

Your first dose was on (DATE/TIME): _____

OR

TIVICAY (dolutegravir) 50mg. Take one pill by mouth daily (every 24 hours). 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 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, Roloids, 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 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).
- 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).
- A Patient Assistance Form has been submitted on your behalf to cover the cost of this prescription or co-pay. Once approved we will contact you with the necessary information to take to the pharmacy along with your prescription. It will be filled at no cost to you.

Your first dose was on (DATE/TIME): _____

