DRAFT MTN-003 PRESCRIPTION

Instructions: All entries must be made in blue or black ink. Press firmly when completing this form. Corrections may be made by drawing a single line through incorrect entries, recording correct information, and initialing and dating the correction.

CRS Name:	**Pre-print**	**DAIDS Site ID:**	**Pre-print**
CRS Location:	**Pre-print**	**Clinic Randomization Envelope #:**	**Pre-print**

Participant ID: ☐☐☐–☐☐☐☐☐–☐

Did participant provide written informed consent for enrollment into MTN-003? ..... *yes* ☐ *no* ☐ Clinic Staff Initials: _____

Assignment: Oral Tablets

Tenofovir Disoproxil Fumarate 300 mg Or Placebo

Sig: Take one (1) tablet by mouth once each day as directed.

Quantity: Sufficient to last until next study visit (as requested by designated clinic staff). May be refilled as needed (as requested by designated clinic staff) for duration of participation in the study.

Emtricitabine 200 mg/Tenofovir Disoproxil Fumarate 300 mg Or Placebo

Sig: Take one (1) tablet by mouth once each day as directed.

Quantity: Sufficient to last until next study visit (as requested by designated clinic staff). May be refilled as needed (as requested by designated clinic staff) for duration of participation in the study.

Authorized Prescriber Name (please print): _____

Authorized Prescriber Signature: _____

Date: ☐☐–☐☐☐–☐☐
dd *MMM* *yy*

Clinic Staff Instruction: Complete all items in this box. After signing and dating, deliver white original to pharmacy. File yellow copy in participant study notebook.

Pharmacy: Dispense ☐ bottles of FTC/TDF 200mg/300mg or placebo (30 tablets/bottle) and ☐ bottles of TDF 300mg or placebo (30 tablets/bottle) to participant as directed in protocol.

Clinic Staff Initials: _____ Date clinic envelope opened: ☐☐–☐☐☐–☐☐
dd *MMM* *yy*