



- HME MCH
 HGM MGH
 HRV RVH
 HNM MNH
 ITM MCI
 CL LC



SHIP frozen specimens to
ICL - 57 Gervais Dr, North York
ON M3C 1Z2

**QUEBEC ANTIRETROVIRAL THERAPEUTIC
DRUG MONITORING PROGRAM**
Data collection for analysis and clinical
Interpretation of plasma concentrations

Referring physician : _____ License No. : _____
 Clinic – Hospital : _____ Telephone No. : _____
 Mailing address : _____ Fax No. : _____

PATIENT INFORMATION:

Weight: _____ kg Height: _____ m Pregnant If yes, # of weeks : _____
 Ethnicity : Asian Black Caucasian Hispanic Native Other : _____

Indication (check all that apply):

- Control Drug interaction
 Virologic failure Toxicity / Adverse reaction: _____
 Low viral load Hepatic impairment
 Pregnancy Off-label dosing
 Pediatrics Validation post-dosage adjustment
 Other: _____

Current medications (prescribed, over the counter, natural health products) OR see attached list of medications

Previous virologic failure to	Yes	No	Cumulative list of mutations
Nucleoside reverse transcriptase inhibitor	<input type="checkbox"/>	<input type="checkbox"/>	OR see attached all genotypes <input type="checkbox"/>
Non-nucleoside reverse transcriptase inhibitor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Protease inhibitor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integrase inhibitor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other class: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

IC₅₀ fold-change for: (if antiretroviral to be analyzed)

Darunavir: _____

Dolutegravir: _____

Etravirine: _____

Rilpivirine: _____

Tipranavir: _____

Last HIV viral load : _____ cop/mL Date of viral load (YYYY/MM/DD) : ____/____/____

SAMPLE PROCUREMENT taken on (YYYY/MM/DD) : ____/____/____ Time (00:00): ____ : ____

Test requested:

(see back)	Dose (mg)	No. doses / day	----- LAST DOSE taken -----		
			Date (MM/DD)	Time (00:00)	With meal?
<input type="checkbox"/> Atazanavir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Darunavir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dolutegravir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Efavirenz	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Elvitegravir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Etravirine	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lopinavir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Nevirapine	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Raltegravir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rilpivirine	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ritonavir	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other: _____	_____	_____	___/___/___	___:___	<input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT
Failure to provide date AND time of sample procurement AND last dose will limit the capacity to interpret the results.

Adherence

No. of doses missed over the last...
 48 hours: _____
 7 days: _____

QUEBEC ANTIRETROVIRAL THERAPEUTIC DRUG MONITORING PROGRAM

Tests available

In addition to the antiretrovirals (ARV) mentioned on the front page, the program if requested can analyse the plasma concentrations of amprenavir (fosamprenavir), indinavir, maraviroc, nelfinavir, saquinavir and tipranavir. The program does not analyse the plasma or intracellular concentrations of nucleoside reverse transcriptase inhibitors, enfuvirtide or cobicistat.

Blood drawing

Blood should be drawn just prior to the next dose. If this is not possible, blood drawing should be done between 6 hours and 14 hours postdose for ARVs administered twice daily or between 12 hours and 26 hours postdose for ARVs administered once daily. Samples taken to measure efavirenz concentrations should be drawn greater than or equal to 10 hours postdose. If malabsorption is suspected, the sample should be drawn at the time expected for the maximum concentration (Tmax).

Tube type

One heparinized (green-top, non gel) tube should be used. One tube is sufficient, even if the request is for more than one ARV.

Data collection form

Please complete the requisition in its entirety as all of the information is essential to the individualization of the pharmacological advice, which will accompany the results. ~~Forward the white and yellow copies (1 and 2) of the requisition with the plasma specimen.~~ **Please do not forget to indicate the ARVs to be tested, the dose, the date and time of the last intake of the ARV to be tested, and the date and time the blood sample was drawn.**

Specimen handling and storage

Ship to ICL

Centrifuge the specimen (3000 x g for 5 minutes) within 6 hours of procurement, ~~and forward the recovered plasma to the Québec Antiretroviral Therapeutic Drug Monitoring Program Laboratory.~~ For adults, send 1 mL of plasma per specimen in a cryotube (1.5 mL size or greater). For children, a 200 µL plasma specimen is sufficient.

Plasma shipped the same day as it is drawn should be kept at 4°C. Otherwise, the plasma should be stored frozen at less than or equal to -20°C until it is sent.

Specimen transport

Samples should be sent only Monday to Wednesday, inclusively, to ensure reception before the weekend. Send the specimen at room temperature (no dry ice) to the Centralized Lab Reception of the McGill University Health Centre (Glen site) at the address indicated below, in accordance with guidelines for shipping infectious materials. If you foresee that shipping will exceed 48 hours, include dry ice in the shipping box and use appropriate safety measures for the use of dry ice.

~~CENTRALIZED LAB RECEPTION – Room E04.1044
McGill University Health Centre
1001 Pécadie Blvd.
Montreal, Quebec H4A 3J1~~

Results and interpretations

Results and interpretation reports will be sent by mail 2 to 3 weeks after we have received the sample. Please remember to indicate your full mailing address on the requisition form.

Contact information

If you have any questions, you may contact ~~the Québec Antiretroviral Therapeutic Drug Monitoring Program from Monday to Friday, 9:00 to 18:00 ET.~~ ICL Client Care (416) 422-3000 info@iclabs.ca

~~Québec Antiretroviral Therapeutic Drug Monitoring Program
McGill University Health Centre
Tel.: (514) 937-9334, ext. 32168
www.mcgill.ca/quebec_tdm~~