Expedited Partner Therapy for Chlamydia and Gonorrhea: Guidance for Health Care Professionals in Oregon

Revised March 2022

Oregon Health Authority

Disclaimer for public health guidelines: These guidelines are intended to be used as an aid to help health care providers make informed patient care decisions. Clinical management should be decided by the health care provider, in consultation with their patient, considering clinical data presented by the patient and the diagnostic and treatment options available. These guidelines are not intended to be regulatory nor to be used as the basis for any disciplinary action against the health care provider.

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Adapted from *Patient-Delivered Partner Therapy (PDPT) for Chlamydia, Gonorrhea, and Trichomoniasis: Guidance for Medical Providers in California* developed by the California Department of Public Health Sexually Transmitted Diseases (STD) Control Branch in collaboration with the California STD Controllers Association and the California Prevention Training Center (CAPTC), issued January 2016.

List of Abbreviations

Abbreviation	Meaning
CDC	Centers for Disease Control and Prevention
EHR	Electronic health record
EPT	Expedited partner therapy
HIV	Human immunodeficiency virus
LPHA	Local public health authority
NAAT	Nucleic acid amplification test
OHA	Oregon Health Authority
PrEP	Pre-exposure prophylaxis
STD*	Sexually transmitted disease
STI*	Sexually transmitted infection

* STD and STI are often used interchangeably, but a sexually transmitted infection is only considered a sexually transmitted disease once a pathogen disrupts the body's normal functioning and causes signs and symptoms.

Introduction

Effective clinical management of patients with treatable sexually transmitted infections/diseases (STI/STD) requires treatment of sex partners to prevent reinfection and curb ongoing transmission. Expedited partner therapy (EPT) is the clinical practice of treating the sex partners of patients with an STI by providing prescriptions or medications to the patient to take to their partner without the health care provider first examining the partner.

EPT is not intended as the first-line partner management strategy and should not replace other strategies, such as provider-assisted partner referral, that facilitate STI and HIV testing and linkage to wraparound HIV/STI services. However, EPT can serve as a valuable alternative strategy when a partner is unable or unlikely to seek care. The Centers for Disease Control (CDC) endorses EPT as a useful option to facilitate partner management, particularly for male partners of women with chlamydia or gonorrhea. Accordingly, the Oregon Health Authority STD/HIV Prevention Program recommends the inclusion of EPT as one strategy in a comprehensive sexual health program.

This document is intended to provide guidance for health care providers dispensing/prescribing EPT for the sex partners of patients infected with *Chlamydia trachomatis* and/or *Neisseria gonorrhoeae*. These guidelines describe the most appropriate patients, medications, and counseling messages for maximizing patient and public health benefit while minimizing risk.

This document replaces “Expedited Partner Therapy (EPT) for Sexually Transmitted Diseases Protocol for Health Care Providers in Oregon” by the Oregon Health Authority Center for Public Health Practice HIV/STD/TB Section, originally published in 2010 and last updated in 2015.

Table 1. Summary of EPT Recommendations.

Expedited Partner Therapy (EPT) for Chlamydia and Gonorrhea: Guidance for Medical Providers in Oregon	
Expedited Partner Therapy (EPT):	Expedited partner therapy (EPT) is the practice of treating the sex partners of patients with STIs by providing prescriptions or medications to the patient to take to their partner, without the health care provider first examining the partner.
Diagnosis of the Patient:	Clinical or laboratory diagnosis of *Chlamydia trachomatis* and/or *Neisseria gonorrhoeae*
Most Appropriate Patients for EPT:	Patients whose partners are unable or unlikely to seek timely clinical services
Recommended EPT Drug Regimens	
Partners of patients diagnosed with chlamydia only	Doxycycline* 100 mg orally twice daily x 7 days **OR** Azithromycin 1 gram orally once
Partners of patients diagnosed with gonorrhea only† (chlamydia has been excluded)	Cefixime‡ 800 mg orally once
Partners of patients diagnosed with gonorrhea and chlamydia (or chlamydia has not been excluded)	Cefixime‡ 800 mg orally once **PLUS** Doxycycline* 100 mg orally twice daily x 7 days *or* Azithromycin 1 gram orally once
* If there are pregnancy or adherence concerns, azithromycin 1 gram orally once is recommended instead of doxycycline † As of December 2020, dual therapy is no longer recommended for treatment of gonorrhea alone ‡ If cefixime is not available, cefpodoxime 400 mg orally every 12 hours x 2 doses can be prescribed	
Number of Partners Eligible for EPT:	All partners in the 60 days before patient's diagnosis (or most recent partner if none in the previous 60 days)
Labeling and Informational Materials:	Medications should be properly labeled; informational materials should include clear instructions and risks; clinic referrals should be provided
Counseling:	Patient and partners should not engage in

	sexual activity for 7 days post-treatment (azithromycin and cefixime) or for the duration of treatment (doxycycline)
Follow-up:	Rescreening for gonorrhea and chlamydia is recommended three months post-treatment
For treatment of index patients, see the CDC STI Treatment Guidelines. **Reporting:** In Oregon, providers are required to report lab-confirmed and clinically suspect cases of chlamydia and gonorrhea infections to public health. To report cases, complete the online Confidential Oregon Morbidity Report Form.	
Adapted from *Patient-Delivered Partner Therapy (PDPT) for Chlamydia, Gonorrhea, and Trichomoniasis: Guidance for Medical Providers in California*, issued January 2016, and the Minnesota Department of Health's *EPT for Chlamydia trachomatis and Neisseria gonorrhoeae: Guidance for Health Professionals*, updated 4/30/2021.	

Public Health Importance

Chlamydia and gonorrhea infections are significant public health concerns. Over 15,000 cases of chlamydia and over 6,000 cases of gonorrhea were reported in Oregon in 2020.[1] Untreated infections can cause significant and costly complications, including pelvic inflammatory disease (PID), epididymitis, disseminated gonococcal infection, and impaired fertility.[2] Individuals with these infections are also at increased risk of acquiring sexually transmitted HIV.[3] Repeat chlamydia and gonorrhea infections occur in 10-15 percent individuals within six months after treatment and increase the risk of complications.[4]

To help prevent repeat infections and complications and to reduce further transmission of infection in the community, sex partners of infected patients must be provided with timely and appropriate treatment.

Barriers to Effective Partner Management

Currently, there are considerable challenges to effective partner management. Public health efforts to notify and treat sex partners have proven successful and are considered a cornerstone of syphilis control.[5] However, because of the high burden of infection and limited public health resources for partner notification activities in the U.S., it is difficult for local health departments to provide investigation and partner notification for all cases of chlamydia and gonorrhea.[6] Thus, the most common strategy for partner management of chlamydia and gonorrhea cases is patient referral—the provider counsels the patient about the importance of treatment for their partner(s) and advises the patient to notify their partners. Providers have the option of collecting contact information for partners and notifying them, however, there are no reimbursement mechanisms, and few clinics have the resources for this activity. The effectiveness of patient referral is limited by the patient's ability to notify their partner(s), as well as by the partner's willingness and ability to access medical care. Partners may encounter barriers related to money, transportation, language, and perceived stigma, that may prevent or delay treatment. Furthermore, infected partners who are asymptomatic may be less likely to seek timely medical treatment.

EPT Policy Background

In 2005, the CDC issued a "Dear Colleague" letter to health care providers stating that EPT is a useful option to facilitate partner management and encouraging states and local health departments to work together to remove operational barriers to EPT.[7] The following year, the CDC published a review of the evidence and guidance for EPT implementation.[8] Since 2012, the CDC has included EPT recommendations in every update of the STD Treatment Guidelines.[9,10] The CDC 2021 STI Treatment Guidelines

recommend that providers routinely offer EPT for chlamydia and gonorrhea when the provider cannot ensure that all partners from the previous 60 days will seek timely treatment. For persons with a penis who have sex with persons with a penis, shared clinical decision-making regarding EPT for chlamydia and gonorrhea is recommended.

In June 2009, the Oregon Legislature passed House Bill 3022 allowing the state's health professional regulatory boards to adopt rules permitting health care practitioners to prescribe treatment for sex partners of patients with certain sexually transmitted diseases without examining the partner.[12] Per this law, an EPT prescription is valid even if the name of the person for whom the prescription is intended is not on the prescription.[12] The legislation directed the Oregon Health Authority to formulate guidance on the practice of EPT in Oregon and specify the STIs for which EPT should be permitted.[12] This document serves as the statutorily required guidance.

Healthcare Provider Role in Partner Management

Because of the risk of repeat infection from untreated partners, patients diagnosed with chlamydia or gonorrhea cannot be considered adequately treated until all their partners have been treated. All partners within the 60 days prior to a patient's positive lab results or onset of symptoms need treatment. In accordance with the 2020 CDC Recommendations for Providing Quality STD Clinical Services, EPT medications for chlamydia and gonorrhea should be available on site in specialized STI care settings, and EPT should be available by prescription (at minimum) as a basic STI care service in primary care settings.[13]

By law, Oregon providers must report lab-confirmed and clinically suspect cases of chlamydia and gonorrhea to the local public health authority (LPHA) for the county where the patient resides.[14] The LPHA may, depending on agency policy and staffing, conduct a case investigation and provide partner services (i.e., notification, testing and treatment, and referrals for services) to prevent further transmission. Providers are encouraged to consult the LPHA for assistance with partner management, particularly in cases involving a patient with multiple STIs or a pregnant patient or partner.

Evidence for Effectiveness of EPT

Several research studies, including randomized clinical trials, have demonstrated that EPT is safe and as effective as other partner management strategies in facilitating partner notification and reducing recurrent infection among index patients, particularly among heterosexual partners of patients with chlamydia or gonorrhea. U.S. trials and a meta-analysis of EPT research show that the magnitude of reduction in reinfection of index patients differed according to the STI and the sex of the index patient, compared with patient referral. Across EPT trials, prevalence of chlamydia and gonorrhea decreased approximately 20% and 50%, respectively, at follow-up.[15-19]

Potential Risks in Using EPT

There are several concerns about EPT. First-line care for partners of patients with an STI includes testing for other STIs and HIV, physical examination to rule out a complicated infection, and risk-reduction counseling. The provision of EPT may decrease the likelihood that partners will seek these first-line services. An additional concern is that the medication could cause a serious adverse reaction. Despite these concerns, EPT is likely to benefit partners who would not otherwise receive timely treatment. These risks can be mitigated through provision of patient education and materials for partners that review adverse effects and encourage visiting a medical provider. Additional concerns about EPT include misuse of medication, waste if the medication is not delivered or not taken, and contribution to antibiotic resistance at the population level. Currently, there is no evidence that EPT is misused or leads to increasing antimicrobial resistance.

Payment for EPT

At present, most partners will need to purchase medications prescribed through EPT. The patient's insurance cannot be billed for the partner's medication unless the partner is covered by the patient's policy and the partner's name is on the prescription. Some settings (e.g., sexual health clinics, community health centers, family planning clinics, school-based health centers) may purchase EPT medications to give directly to patients to give to partners. Partners who seek medical care in a setting with EPT available on-site should be given the recommended first-line treatment (e.g., ceftriaxone for gonorrhea) rather than EPT.

Selecting Appropriate Patients for EPT

Appropriate patients are those with a laboratory or clinical diagnosis of sexually transmitted chlamydia or gonorrhea infection. Laboratory confirmation may be based on culture or NAAT findings. Providing EPT without laboratory confirmation should be considered when there is high clinical suspicion for chlamydia or gonorrhea infection and concern about loss to follow-up.

The most appropriate patients for EPT are those with partners who are unable or unlikely to seek prompt clinical services. Factors to consider include whether the partner is uninsured, lacks a primary care provider, faces significant barriers to accessing clinical services, or may be unwilling to seek care. Providers should also assess the acceptability of EPT to both the patient and the partners receiving it. Even when EPT is provided, partners should still be encouraged to seek care as soon as possible.

Providers should attempt to bring partners in for comprehensive health care, including evaluation, testing, and treatment. Clinical services provide the opportunity to ensure treatment; confirm the exposure and/or diagnosis; examine the patient; test for other STIs and HIV; offer reproductive health services; provide needed vaccinations; discuss HIV pre-exposure prophylaxis (PrEP), a prevention strategy in which people who don't have HIV take antiretroviral drugs to reduce their risk of getting HIV; and offer health education and community referrals.

All sex partners in the 60 days prior to diagnosis with sexually transmitted chlamydia or gonorrhea may have been exposed and should be treated. If the last sexual encounter was more than 60 days prior to diagnosis, the most recent sexual partner should be treated. There is no limit to how many partners may be treated using EPT. Patients can be provided with the number of doses necessary to treat each exposed partner. A combination of partner strategies also may be used; a patient with several partners may refer one partner to the clinic but take EPT for other partners.

Providers should ask the patient about each partner's symptoms, particularly symptoms suggesting a complicated infection; their pregnancy status; and their risk for severe medication allergies. EPT should not be provided for partners with known severe allergies to antibiotics. If a partner is pregnant, every effort should be made to engage them in care; EPT should be considered a last resort after attempting to link a pregnant partner to care.

EPT is <u>not</u> appropriate in the following scenarios: patient co-infection with treatable STIs that are not covered by EPT medication; cases of suspected child abuse, sexual assault, or intimate partner abuse; or situations in which the patient's safety is in question.

Recommended EPT Regimens

Table 2. Recommended Antibiotic Regimens for EPT.

Infection Diagnosed in Index Patient	Recommended EPT Regimen
Chlamydia only	Doxycycline* 100 mg orally twice daily x 7 days **OR** Azithromycin 1 gram orally once
Gonorrhea only—chlamydia has been excluded	Cefixime† 800 mg orally once
Gonorrhea—chlamydia has not been excluded	Cefixime† 800 mg orally once **PLUS** Doxycycline* 100 mg orally twice daily x 7 days

* If there are pregnancy or adherence concerns, azithromycin 1 gram orally once is recommended instead of doxycycline
† If cefixime is not available, cefpodoxime 400 mg orally every 12 hours x 2 doses can be prescribed

Antibiotic Resistance and Gonorrhea

Since 2010, CDC had recommended dual therapy for gonorrhea with ceftriaxone and azithromycin. Increasing concern for antimicrobial stewardship, along with the continued low incidence of ceftriaxone resistance and increases in azithromycin resistance, led to re-evaluation of this recommendation.[20] In December 2020, the CDC released updated recommendations for the treatment of gonorrhea. The first-line treatment for gonorrhea infection is now a single intramuscular injection of ceftriaxone 500 mg for persons weighing <150 kg and 1 g for persons ≥150 kg; dual therapy is no longer recommended for first-line treatment or EPT. Public health surveillance and provider reporting of treatment failures are essential in monitoring for antibiotic resistance and preserving the efficacy of recommended regimens.

Procedure for Dispensing or Prescribing EPT

EPT medication may be dispensed or prescribed. The preferred method is practitioner dispensing of a pre-packaged “partner pack” to the index patient to take to their partner(s) that includes medication, educational materials, and clinic referrals. If practitioner dispensing is not possible, prescriptions can be provided for pharmacy dispensing. Prescriptions should also be accompanied by educational materials for the partner. There is no limit to how many partners may be treated using EPT.

Prescriptions must be written separately for the index patient and for each of the index patient’s partners. A single prescription for the index patient and for each of the index

patient's partners is not permitted. An EPT prescription is valid even if the name of the partner is not on the prescription.[12] If the index patient is unwilling or unable to identify the partner(s) by name, the prescriber must write a prescription for each partner that includes a reference to EPT on the face of the prescription (e.g., "[name of original patient]—Partner," "EPT Partner," or "for EPT"). See Appendix for examples of EPT prescriptions.

Providers who e-prescribe through an electronic health record (EHR) system may encounter challenges sending EPT prescriptions. One common barrier is the inability to e-prescribe EPT for unnamed partners. If the EHR cannot be formatted to permit this, then multiple prescriptions can be issued under the index patient name with a note on the prescription (e.g., "EPT Partner" or "for EPT") or other non-electronic prescribing options should be utilized. These non-electronic options include providing paper prescriptions for unnamed partners (annotated as indicated above) or calling in the prescriptions to a pharmacist.

The requirements that pharmacies must follow when dispensing EPT prescriptions can be found in OAR 855-041-4005. If the prescription issued by the prescriber does not meet these requirements, the pharmacist is required to contact the prescriber or the prescriber's agent to obtain any missing or additional information.

Risks and Special Populations

Adverse Drug Reactions

Adverse reactions to the medications used for EPT for chlamydia and gonorrhea, beyond mild to moderate side effects, are rare. This risk of allergy and adverse drug reactions may be best mitigated through accompanying educational materials that include explicit warnings and instructions for partners who may be allergic to penicillin, cephalosporins, tetracyclines, or macrolides to seek medical advice before taking the medication. Known adverse reactions to cefixime, doxycycline, and azithromycin are listed below.

Cefixime—Adverse Drug Reactions
• Cefixime is generally well tolerated. Common side effects are gastrointestinal, primarily diarrhea and nausea.[21]
• Approximately 1-3% of patients have a primary hypersensitivity to cephalosporins.[22] The risk of anaphylaxis with cephalosporins in the general population is between 1 in one million and 1 in 1000 (0.0001-0.1 percent).[23-25]
• Third-generation cephalosporins (e.g., ceftriaxone, cefixime, and cefpodoxime) have lower cross-reactivity with IgE-mediated penicillin-allergic patients (<1%) compared with first- and second-generation cephalosporins (range 1%-8%). Anaphylaxis secondary to cephalosporins is extremely rare among persons who report a penicillin allergy and is estimated to occur at a rate of one per 52,000

persons.[26] Use of third-generation cephalosporins is safe for patients without a history of any IgE-mediated symptoms (e.g., anaphylaxis or hives) from penicillin during the preceding 10 years. [11] Individuals with anaphylaxis or other IgE-mediated symptoms secondary to penicillin may require further evaluation prior to the use of cephalosporins.
• Cefixime has been assigned to pregnancy category B: Animal studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant people.

Doxycycline—Adverse Drug Reactions
• Doxycycline is generally well tolerated.[27] Common side effects include nausea, vomiting, diarrhea, rash, and photosensitivity.
• Anaphylaxis or severe allergy to doxycycline is very rare.
• Doxycycline has been assigned to pregnancy category D: There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.
• Use of doxycycline in pregnancy might be associated with discoloration of teeth; however, the risk is not well defined. Doxycycline is compatible with breastfeeding.[11]

Azithromycin—Adverse Drug Reactions
• Azithromycin is generally well tolerated.[28] The most common side effects in patients receiving a single-dose regimen of one gram of azithromycin are gastrointestinal, primarily diarrhea, nausea, and abdominal pain.
• Anaphylaxis or severe allergy to macrolides generally, or to azithromycin specifically, is very rare.
• Azithromycin has been assigned to pregnancy category B: Animal studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant people.

Undertreating Pharyngeal Gonorrhea

Inadequate treatment of partners with pharyngeal gonorrhea is a potential limitation of EPT. Cefixime does not provide as high or as sustained bactericidal tissue levels as ceftriaxone and demonstrates limited treatment efficacy for pharyngeal gonorrhea. Providers who are concerned that a partner is at risk for pharyngeal infection (i.e., history of performing oral sex on a person with a penis) should advise the patient that

oral treatment may not cure pharyngeal gonorrhea. The partner should seek clinical services where injectable ceftriaxone is available.

Missing Concurrent STI/HIV Infections

EPT can be used regardless of the patient's gender or sexual orientation. However, the use of EPT may increase the risk of under-treating a complicated infection or missing a concurrent STI/HIV infection, particularly among persons with a penis who have sex with persons with a penis. Persons with a penis who have sex with persons with a penis demonstrate higher resistance to cefixime and higher risk of co-infection with syphilis and/or HIV among this population with gonorrhea. Shared clinical decision-making regarding EPT is recommended with these patients.

The risk of missing concurrent STI/HIV infections can be mitigated through educational materials that clearly instruct all EPT recipients to seek prompt medical evaluation, regardless of whether they take the medication.

Pregnancy

Although EPT is not contraindicated when a patient reports that a partner may be pregnant, providers should assess whether the pregnant partner is receiving pregnancy services or prenatal care. Every effort should be made to contact the pregnant partner and ensure appropriate care; EPT should be considered a last resort. The local health department may be of assistance in following up on these high-priority partners. Cephalosporins and azithromycin are considered safe in pregnancy. Doxycycline should not be used in pregnancy.

Key Education and Counseling Messages

Ideally, EPT medications and educational material should be given to the patient to deliver to the partner. If an EPT prescription is given, then the provider should encourage the patient to fill it and deliver the medication and accompanying educational material to the partner. Providers should discuss the following key counseling messages with their patient when prescribing EPT.

Key Counseling Messages for EPT

- Partners should seek a complete STI evaluation as soon as possible, regardless of whether they take the medication.
- Partners should read the educational material carefully before taking the medication.
- Partners who have allergies to antibiotics or who have serious health problems should not take the medications and should see a healthcare provider.
- Partners who have symptoms of a more serious infection (e.g., pelvic pain, testicular pain, fever) should not take the medications and should seek care as soon as possible.

- Partners who are or could be pregnant should seek care as soon as possible.
- Patient and partners should not engage in sexual activity for 7 days post-treatment (azithromycin and cefixime) or for the duration of treatment (doxycycline).
- Partners should be advised to seek clinical services for retesting three months after treatment.

Additional Counseling Message about Pharyngeal Gonorrhea

- Partners who are at risk for gonorrhea infection in the pharynx (history of performing oral sex on a person with a penis) should be informed that the EPT medicines given to them may not cure pharyngeal gonorrhea and advised to seek care regardless of whether they take the medication.

Follow-up and Rescreening

Patients should be rescreened three months after treatment, regardless of whether they believe that their sex partners were treated.[11] Partners should also be encouraged to get tested three months after treatment. All persons who receive STI diagnoses and their partners, particularly persons with a penis who have sex with persons with a penis, should be tested for HIV. HIV PrEP should be offered if HIV testing is negative and rapid linkage to HIV care should be initiated if positive.

Resources

Oregon EPT Resources

- EPT partner information materials are available at www.healthoregon.org/std.
- Information on the Oregon statute authorizing EPT is available at www.oregonlegislature.gov under ORS 676.350. The Oregon administrative rule detailing pharmacy procedure for providing EPT is available at https://secure.sos.state.or.us/oard under OAR 855-041-4005.
- For information on local STI control efforts, please contact your local STI control program, visit the Oregon Health Authority STD Prevention website (www.healthoregon.org/std), or call the Oregon Health Authority STD Prevention program at (971) 673-0153.

Clinical Practice Guidelines

- Sexually Transmitted Disease Treatment Guidelines https://www.cdc.gov/std/treatment/
- Expedited Partner Therapy in the Management of Sexually Transmitted Diseases www.cdc.gov/std/EPT

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Revision History

February 2010. Original publication.

September 2012. Revision removed gonorrhea from the list of conditions for which EPT recommended and removed allusions to use of EPT for gonorrhea. Changes were made in response to concerns about increasing minimum inhibitory concentrations of cephalosporins for gonorrhea isolates and recommendation by Centers for Disease Control and Prevention that injectable ceftriaxone be the sole preferred medication for treatment of gonorrhea.

July 2014. Revision replaced gonorrhea among conditions for which EPT recommended. Changes were made amidst historic increases in gonorrhea incidence, reiteration of CDC recommendations for use of cefixime for EPT in gonorrhea cases despite retraction in 2012 of recommendation for cefixime as alternative treatment to ceftriaxone for index cases. In addition, gonococcal isolate surveillance continues to indicate that sensitivity to cefixime remains high in Oregon.

February 2015. Formatting update.

February 2022. Revision updated drug and dosage recommendations in accordance with the CDC 2021 STI Treatment Guidelines. Revision added recommendations (with caveats) to provide EPT for partners of any gender and sexual orientation; pregnant partners; and persons with a penis who have sex with persons with a penis. Revision updated sections addressing EPT risks and use with special populations, key education and counseling messages, and follow-up recommendations. Extensive formatting and language revisions.

You can get this document in other languages, large print, braille, or a format you prefer. Contact the STD Prevention Program at 971-673-0153 or email jillian.d.garai@state.or.us. We accept all relay calls or you can dial 711.

Appendix: Example EPT Prescriptions

1. EPT Prescription for Gonorrhea and Chlamydia for One Partner

NAME: **INDEX PATIENT** WRITTEN DATE: **1/1/2022**

DOB: **XX/XX/XXXX** EXPIRATION DATE: **1/31/2022**

ADDRESS: **123 INDEX PATIENT DRIVE, PORTLAND, OR 97232**

℞ EPT Prescriptions for Gonorrhea and Chlamydia for 1 Partner:

1. **Cefixime 400 mg tablet**
   Take 2 tablets (800 mg) PO once for EPT/Gonorrhea
   #2 tablets, 0 refills

2. **Doxycycline 100 mg tablet**
   Take 1 tablet PO BID for 7 days for EPT/Chlamydia
   #14 tablets, 0 refills

Signature	NPI Number
Dr. Stop Gee Cee	1234567891

ADDRESS: **123 PRESCRIBER DRIVE, PORTLAND, OR 97232**

PHONE: **503-123-4567**

2. EPT Prescription for Gonorrhea for Index Patient with Multiple Partners—Separate Rx for Each Partner*

NAME: **INDEX PATIENT- PARTNER 1** WRITTEN DATE: **1/1/2022**
DOB: **XX/XX/XXXX** EXPIRATION DATE: **1/31/2022**
ADDRESS: **123 INDEX PATIENT DRIVE, PORTLAND, OR 97232**

℞

Cefixime 400 mg tablet
Take 2 tablets (800 mg) PO once for EPT/Gonorrhea
#2 tablets, 0 refills

Note: For Index Patient Partner 1 of 3

Signature	NPI Number
Dr. Stop Gee Cee	1234567891

ADDRESS: **123 PRESCRIBER DRIVE, PORTLAND, OR 97232**
PHONE: **503-123-4567**

* A numbering system may be used when prescribing for multiple partners (e.g., Partner 1, Partner 2) since partner names are not required on EPT prescriptions.

3. EPT Prescription for Chlamydia for Index Patient with Multiple Partners—Separate Rx for Each Partner*

NAME: **INDEX PATIENT- PARTNER 1** WRITTEN DATE: **1/1/2022**
DOB: **XX/XX/XXXX** EXPIRATION DATE: **1/31/2022**
ADDRESS: **123 INDEX PATIENT DRIVE, PORTLAND, OR 97232**

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Doxycycline 100 mg tablet
Take 1 tablet PO BID for 7 days for EPT/Chlamydia
#14 tablets, 0 refills

Note: For Index Patient Partner 1 of 3

Signature	NPI Number
Dr. Stop Cee Tee	1234567891

ADDRESS: **123 PRESCRIBER DRIVE, PORTLAND, OR 97232**
PHONE: **503-123-4567**

* A numbering system may be used when prescribing for multiple partners (e.g., Partner 1, Partner 2) since partner names are not required on EPT prescriptions.