CLINICAL GUIDELINES PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV • HCV • STIs • SUBSTANCE USE • LGBTQ+ HEALTH

Questions, Answers, and Best Practices for Expedited Partner Treatment (EPT)

Updates, Authorship, and Related Resources

Date of current publication	April 29, 2025
Highlights of changes, additions, and updates in the April 29, 2025 edition	• Definition, Legality, Eligibility, and Barriers section: Added 2 new questions and answers: – If the index patient's sex partner is taking doxy-PEP, are they eligible for EPT? – What are the barriers to EPT? • Treatment, Medications, and Follow-Up section: – Updated treatment regimens for gonorrhea and trichomoniasis in Table 1: Preferred and Alternative Regimens for Expedited Partner Treatment (EPT) – Added Box 2: Prescribing Expedited Partner Treatment (EPT) in New York State
Intended users	Clinicians who provide sexual health care, including testing and treatment for sexually transmitted infections
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Related NYSDOH AI resources	**Guidelines** • Doxycycline Post-Exposure Prophylaxis to Prevent Bacterial Sexually Transmitted Infections • PrEP to Prevent HIV and Promote Sexual Health **Guidance** • Guidance: Adolescent Consent to HIV and STI Treatment and Prevention **Podcast** • Viremic—Cases in HIV

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Purpose of This Guidance

Sexually transmitted infections (STIs) are a significant cause of morbidity and mortality and may result in infertility, chronic abdominal pain, and an increased risk of acquiring HIV. In 2023, New York State ranked 7th and 10th among all states for total number of cases of gonorrhea and chlamydia, the most common bacterial STIs, respectively [CDC(b) 2024]. As of 2022, New York State cases of gonorrhea increased for the ninth consecutive year and cases of chlamydia increased for the second consecutive year after declining in 2020; people aged <24 years, non-Hispanic Black individuals, and men who have sex with men had the highest rates of STIs [NYSDOH(b) 2024]. It is imperative that all patients with STIs and their sex partners are treated to interrupt chains of transmission, help combat rising STI numbers, and move toward ending the STI epidemic. Expedited partner treatment (EPT) is an essential health service that can help combat the rising number of cases and is designed to be a low-barrier intervention. The New York State Department of Health (NYSDOH) encourages clinicians to take steps to make EPT as available as possible [NYSDOH(a) 2024].

The answers to the frequently asked questions below offer guidance for clinicians who provide sexual health care, including testing and treatment for STIs. The goal is to inform clinicians about existing regulations that allow expedited treatment of

sex partners of individuals diagnosed with gonorrhea, chlamydia, or trichomoniasis. EPT is not allowed for treatment of bacterial vaginosis or syphilis (see information regarding syphilis management in guidance section Definition, Legality, Eligibility, and Barriers).

More information is available through these resources:

- NYSDOH: Expedited Partner Treatment Information for Providers and Pharmacists
- New York City Health: Expedited Partner Therapy
- Centers for Disease Control and Prevention (CDC): 2021 STI Treatment Guidelines
- Clinical Education Initiative

Definition, Legality, Eligibility, and Barriers

What is EPT?

Expedited partner treatment, or EPT, is the clinical practice of providing prescription medication for sexually transmitted infection (STI) treatment without a healthcare visit for the sex partners of patients with a newly diagnosed STI. In New York State, EPT is permissible for chlamydia, gonorrhea, and trichomoniasis [CDC(a) 2024; NYSDOH(a) 2024]. EPT is an opportunity to lower the threshold to an essential sexual health service and make treatment broadly available. **EPT is not intended to replace clinic visits but to provide an alternative strategy for treating sex partners who are unable or unwilling to see a care provider for treatment.** Clinic visits provide opportunities for STI screening in individuals who may require treatment for an STI other than the infection being treated with EPT. A visit with a care provider also offers the opportunity to provide additional services, such as risk-reduction counseling, HIV pre-exposure prophylaxis, and HIV and hepatitis B and C screening.

→ KEY POINT

- The best practice for STI care is to see and evaluate the sex partner(s) of an index patient diagnosed with an STI. If asked, an index patient may be able to bring their sex partner(s) with them when they come for treatment.

Is EPT legal?

Yes, in New York State, EPT is explicitly legal under NYS Public Health Law Section 2312 and can be provided for treatment of chlamydia, gonorrhea, and trichomoniasis, as recommended by the CDC: 2021 STI Treatment Guidelines.

EPT is permissible or potentially allowable in 50 states. State laws determine the STIs covered, who can receive EPT, and how it can be provided. Clinicians should review state-specific guidance before providing EPT.

Who is eligible for EPT?

Sex partners of patients with a clinical or laboratory diagnosis of gonorrhea, chlamydia, or trichomoniasis (referred to as index patients) are eligible for EPT, which can be prescribed regardless of the sexual or gender identity of the index patient or their sex partner.

There is no age threshold for EPT in New York State. According to NYS Public Health Law Section 2305, individuals aged <18 years may give effective informed consent for services related to screening, treatment, and prevention of STIs. Therefore, EPT is applicable for patients of any age and their sex partner(s).

Box 1: Eligibility for Expedited Partner Treatment (EPT) [a]	
Eligible for EPT	**Not eligible for EPT**
• Patients with a clinical (without laboratory confirmation) or laboratory diagnosis of chlamydia, gonorrhea [b], or trichomoniasis (referred to as index patients) • All sex partners exposed within 60 days before the index patient's symptom onset or diagnosis • The most recent sex partner, if the index patient has had no sex partners within 60 days of the diagnosis	• Patients known to have syphilis in addition to gonorrhea, chlamydia, or trichomoniasis • Cases involving suspected or confirmed abuse (i.e., child abuse, sexual assault, or sexual abuse)
Notes: a. Per New York State public health law, individuals aged <18 years may give effective informed consent for services related to screening, treatment, and prevention of sexually transmitted infections. b. Ceftriaxone remains the treatment of choice for gonorrhea, particularly for pharyngeal infections, for which data on treatment efficacy are limited and higher drug levels may be required.	

Why are patients known to have syphilis not eligible for EPT?

The recommended management of sex partners of individuals diagnosed with syphilis varies significantly depending on the stage of syphilis in the index patient. No data support use of EPT to treat sex partners of patients with syphilis. Partner services offered through state or local health departments are available to assist with sex partner treatment for syphilis throughout New York State. Of note, a clinician may prescribe EPT for gonorrhea, chlamydia, and trichomonas to a patient while syphilis test results are pending or if they are unable to be tested (e.g., a symptomatic telehealth visit). If the diagnosis of syphilis was unknown at the time EPT was prescribed, there is no liability.

If the index patient's sex partner is taking doxy-PEP, are they eligible for EPT?

Yes. However, if the index patient's sex partner is already taking doxycycline post-exposure prophylaxis (doxy-PEP), it is important to assess whether they truly need EPT. Patients should be encouraged to have an open discussion with their sex partner to determine whether they have taken doxy-PEP after all recent sexual encounters with the index patient.

If the sex partner has adhered to doxy-PEP appropriately and consistently following these encounters and has no symptoms, treatment through EPT may not be necessary. However, because doxy-PEP is not 100% effective at preventing STIs, especially gonorrhea, it is important for patients using doxy-PEP who have sex partners diagnosed with bacterial STIs to undergo STI testing. This can help avoid unnecessary antibiotic use and reinforce the sex partner's understanding of their STI prevention plan. Alternatively, sex partners may still elect to use EPT after a known exposure to gonorrhea or chlamydia despite prior use of doxy-PEP. In this situation, no more than 200 mg of doxycycline should be taken in 24 hours (i.e., doxycycline as EPT and doxy-PEP should not be taken together).

What are the barriers to EPT?

Barriers to the provision of EPT include a lack of pharmacy and pharmacist awareness of EPT, concerns about legal liability, variability in state laws and regulations, limited reimbursement mechanisms, and uncertainty regarding patient counseling and follow-up procedures [Solnick, et al. 2025; Wong, et al. 2020; Qin, et al. 2018].

Strategies to overcome these barriers include:

- Use of the electronic health record (EHR) to encourage and lower the barrier to EPT prescribing: Integrating EPT protocols into EHR systems can prompt clinicians to consider EPT during patient visits, streamline the prescribing process, and facilitate documentation [Brown, et al. 2024].
- Care provider education and standardization for STI/EPT notification and counseling: Educational interventions, such as public health detailing, have been shown to improve awareness of EPT, increase EPT implementation, and reduce barriers to prescribing EPT [Richards, et al. 2024; Milkovich, et al. 2021].

- Availability of take-home kits: Providing patients with medication or prescriptions to deliver to their sex partner(s), along with educational materials, has been effective in ensuring partner treatment and reducing rates of reinfection [Ager, et al. 2023].
- Patient education and engagement: Educating patients about the importance of partner treatment and providing them with resources to communicate with their partner(s) can enhance the effectiveness of EPT [Carman-McClanahan and McCool-Myers 2020].

Treatment, Medications, and Follow-Up

Which medications should be used for EPT?

Table 1, below, summarizes preferred and alternative regimens for expedited partner treatment (EPT), which are aligned with the CDC: 2021 STI Treatment Guidelines.

Table 1: Preferred and Alternative Regimens for Expedited Partner Treatment (EPT)
CDC: 2021 STI Treatment Guidelines

STI	Preferred EPT Regimen	Alternative EPT Regimen	Comments
Chlamydia	Doxycycline 100 mg by mouth twice daily for 7 days *OR* Azithromycin 1 g by mouth in a single dose	Levofloxacin 500 mg by mouth daily for 7 days	• Doxycycline and levofloxacin are contraindicated in pregnancy. • Azithromycin is recommended for treatment of chlamydia in patients with unknown pregnancy status.
Gonorrhea	Cefixime 800 mg by mouth in a single dose	—	Treat for chlamydia if it has not been excluded.
Trichomoniasis	**Female sex partners:** Metronidazole 500 mg by mouth twice daily for 7 days *OR* Tinidazole 2 g by mouth in a single dose **Male sex partners:** Metronidazole 2 g by mouth in a single dose	**Female sex partners:** Metronidazole 2 g by mouth in a single dose	Counsel symptomatic pregnant patients with trichomoniasis regarding the potential risks and benefits of treatment.

Abbreviation: STI, sexually transmitted infection.

Is the treatment for an index patient and a sex partner always the same?

The index patient's and sex partner's EPT regimens may differ based on individual patient factors. For guidance on the treatment of the index patient, see CDC: 2021 STI Treatment Guidelines.

How do I provide EPT medications?

Clinicians may dispense EPT medications in person at the point of care or may provide a prescription for the medications. Issuing extra doses or refills to an index patient's prescription as a means to treat sex partners is not permitted (see NYSDOH: EPT FAQs for Health Care Providers and Pharmacists).

Partner packs, dispensed in person, are preferred. Partner packs include medication for the index patient and the sex partner along with informational materials and clinic contact options.

Per New York State law, when dispensed, partner packs must be labeled with the name and address of the dispenser, directions for use, date of delivery, the proprietary or brand name of the drug, and the strength of the contents.

However, not all clinical environments may be able to dispense EPT in this way. When partner packs are not available, clinicians can provide a prescription to the index patient for their sex partner, along with informational materials and clinic contact information.

Prescribed ("Prescription – EPT"): If providing a prescription for EPT, the prescription must have "EPT" in the comments below the care provider information and above the medication, the dosage, refills (0), and instructions for use. The prescription may be issued electronically or on an official New York State prescription form. No identifiable information is required; per NYS Public Health Law Section 2312, a pharmacist can fill a prescription with the designation of "EPT" even when a sex partner's name, address, and date of birth are not listed on the prescription. The partner is responsible for the cost of the medications. See Box 2, below, and the NYSDOH: EPT FAQs for Health Care Providers and Pharmacists for answers to common questions regarding EPT prescriptions. Information on electronic prescribing rules, regulations, and allowable exemptions (including EPT) in New York State can be found at NYSDOH: Electronic Prescribing.

Box 2: Prescribing Expedited Partner Treatment (EPT) in New York State [a,b]

- If the sex partner's name, address, and date of birth are available at the time the electronic prescription is issued, enter them in the designated prescription fields.
- If the sex partner's name, address, and date of birth are not available at the time the electronic prescription is issued, enter the following in the designated prescription fields:
  - First name: Expedited
  - Last name: Partner
  - Gender: Use available values
  - Date of Birth: Use 1/1/1901 if unknown
  - Street: "Pharmacy Should Request Address"
  - City, State, and Zip Code: Default to the city, state, and zip code of prescriber or pharmacy
- Additional options for generating electronic EPT prescriptions:
  - Some sites use a dummy patient profile (e.g., "Partner, Expedited" as above) under which EPT prescriptions can be entered and transmitted electronically to a pharmacy. The sex partner's name and contact information are placed in the section for comments to the pharmacist (e.g., *"This is an EPT Rx for recipient XYZ."*).
  - Some sites issue additional prescriptions within the index patient's electronic health record and include comments to the pharmacist that 1) the prescription is for EPT and should be issued for the sex partner of the index patient and 2) the index patient should not be billed (e.g., *"For EPT; do not bill this patient."*).
- If electronic EPT prescribing is not available, issue a paper prescription. EPT is an exemption to mandated electronic prescribing [c].

Notes:

a. See NYSDOH: EPT FAQs for Health Care Providers and Pharmacists.
b. See National Council for Prescription Drug Programs: Real-Time Prescription Benefit (TRPB) Standard Implementation Recommendations (August 2021).
c. See NYSDOH: Exceptions to Electronic Prescribing.

★ NEW YORK STATE LAW

- Medications must be labeled with the name and address of the dispenser, directions for use, date of delivery, the proprietary or brand name of the drug, and the strength of the contents [NYS Senate 2014].

Who is responsible for paying for EPT medications?

Medication costs are the responsibility of the sex partner and may be paid for in cash or through health insurance coverage. The index patient's insurance cannot be billed for medications for a sex partner. If an index patient's partner is uninsured, then the best approach is to provide the EPT medications in person when available. When EPT medications cannot be provided in person, partners should be sent to a local health department to cover the cost of the prescription.

How should I follow up?

Contact the index patient and, with consent, their sex partner by phone to ensure they have or will pick up the medications and that symptoms resolve. Schedule follow-up visits for index patients if symptoms persist or at 3 months for repeat testing because of the risk of reinfection. Advise that sex partners follow up for comprehensive sexual health services as soon as they are able.

Patient Education

What points should be covered in EPT education with patients?

- Advise index patients to inform their sex partner(s) that they may have been exposed to a sexually transmitted infection (STI; chlamydia, gonorrhea, and/or trichomoniasis) and should seek evaluation and treatment even if they do not have symptoms.
- Emphasize that sex partners should read the educational information provided **before** they take the expedited partner treatment (EPT) medication.
  - Educational materials for patients are available from New York State and New York City.
- Make clear that the sex partner should seek medical care **before** starting the EPT medication if they:
  - Are allergic to antibiotics
  - Have abdominal pain, pelvic pain, testicular pain, fever, nausea, vomiting, or other symptoms of serious illness that require evaluation and may require treatment beyond EPT
  - Are pregnant or could be pregnant
  - Have serious health problems
  - Are taking prescription or nonprescription drugs, because potentially dangerous drug-drug interactions could occur
- Educate index patients and sex partners about:
  - The possibility that additional treatment may be needed if the index patient or sex partner has an STI that is not covered by the delivered EPT
  - Abstaining from sexual activity without the use of barrier protection for at least 7 days after treatment is ended to decrease the likelihood of reinfection
  - Prevention of STIs in the future, including the use of barrier protection and PrEP for prevention of HIV
  - The preferred approach to STI care for sex partners, including those who took doxy-PEP (doxycycline post-exposure prophylaxis) after every sexual encounter, which is to see a clinician for a complete STI evaluation, including HIV testing, even if they take the EPT medications

Where can I find free educational materials?

New York State offers free educational materials for distribution to partners in English and Spanish. These materials may be distributed with a digital link or a QR code or ordered through the NYSDOH website. New York City also offers free educational materials in additional languages.

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Supplement: Guideline Development and Recommendation Ratings

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Developer	New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program
Funding source	NYSDOH AI
Program manager	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See Program Leadership and Staff.
Mission	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
Expert committees	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
Committee structure	• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor • Contributing members • Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders
Disclosure and management of conflicts of interest	• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation. • The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.
Evidence collection and review	• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update. • A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations. • A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years. • Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.
Recommendation development	• The lead author drafts recommendations to address the defined scope of the guideline based on available published data. • Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations. • When published data are not available, support for a recommendation may be based on the committee's expert opinion. • The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Review and approval process	• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee. • Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations. • Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.
External reviews	• External review of each guideline is invited at the developer's discretion. • External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.
Update process	• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations. • If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.

Table S2: Recommendation Ratings and Definitions		
Strength	**Quality of Evidence**	
A: Strong B: Moderate C: Optional	1	Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*	Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2	Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2†	Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3	Based on committee expert opinion, with rationale provided in the guideline text.