# Provider Referral Form for Insured Clients

## Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

The client below is newly enrolled in the PrEP-AP administered by the California Department of Public Health (CDPH). The client may be eligible to receive assistance from CDPH for PrEP-related medical out-of-pocket costs, including deductibles, coinsurance, and medical copayments. You are being provided this referral form to communicate the CDPH PrEP-AP as a possible secondary payer source after the client's primary insurance coverage. **Providers must verify client eligibility in PrEP-AP prior to rendering services. Client eligibility can be verified by calling CDPH at 1-844-421-7050.**

**Please fill out the Clinical Provider Section of this form and fax the completed form to the client's enrollment worker at the number below.**

Allowable PrEP-related services are limited to very specific medical billing codes that include assistance toward clinical assessments for PrEP eligibility as an HIV prevention measure and on-going monitoring and evaluation as recommended by the Centers for Disease Control and Prevention Clinical Practice Guidelines for PrEP. Please visit the PrEP-AP Resources page to find a comprehensive list of allowable ICD-10 codes and medical billing codes. All claims must also include an ICD-10 code(s) substantiating the provider visit as being PrEP-related.

**Please do not charge the client a copay for PrEP-related services for any reason.** To receive payment for allowable PrEP-related services, please bill the PrEP-AP's Medical Benefits Manager, Pool Administrators, Inc. (PAI) and provide supporting documentation using one of the methods indicated below. PAI will remit payment within 60 days of receiving a valid claim.

1. Electronically: Payer ID: PAI02
2. Mail: PAI-CDPH - 02, 628 Hebron Avenue, Suite 502, Glastonbury, CT 06033
3. Fax: 860-724-4599
4. Email Address: CDPHPrEP@pooladmin.com

**Enrollment Worker complete the following:**

Check here if the client is already enrolled in the Gilead Patient Assistance Program and does not require a clinical assessment to be prescribed PrEP

**Client Name:** ______________________ **PrEP-AP ID Number:** ______________

**Enrollment Worker Name**: ______________________ **Phone:**

**Email:** ________________ **Fax:** ________________

**Name and address of agency client was referred to:** ______________________________

______________________________

## Health Plan In-Network Provider complete the following:

**Provider Name:** ______________________________ **NPI Number:** ______________________________

Client is **HIV negative** and clinically eligible for PrEP and will be prescribed:

Truvada® Generic TDF/FTC Descovy®

**For HIV negative clients only**, please fax this form and the completed Gilead application to the enrollment worker identified above. Clients with private insurance whose health plans cover the full cost of PrEP do not need to enroll into Gilead's co-pay assistance effective June 11, 2020. Clients should contact their health plan to determine if they cover the full cost of PrEP.

Client is **HIV positive** and not eligible for PrEP (complete the following steps)

1. Please initiate rapid antiretroviral therapy in accordance with the policy outlined in *PrEP-AP Provider Network Policy Document 2019-02: Initiation of Rapid Antiretroviral Therapy Due to Seroconversion*, or refer client to a clinical care provider ideally with a same day appointment
2. Indicate here which rapid antiretroviral regimen will be used, if applicable:

   Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy®) fixed dose combination 1 tablet once daily **-** *Preferred regimen*

   Dolutegravir (Tivicay®) 50 mg once daily + tenofovir alafenamide/emtricitabine (Descovy®) 1 tablet once daily **-** *Preferred regimen*

   Darunavir/cobicistat/emtricitabine/tenofovir alafenamide (Symtuza®) fixed dose combination 1 tablet once daily

   Raltegravir (Isentress® HD) 1200 mg (two pills) once daily + tenofovir alafenamide/emtricitabine (Descovy®) 1 tablet once daily (raltegravir can also be dosed 400mg twice daily)

   Other (Please specify regimen including dose): ______________________________

3. Provide the client with this form and a completed *Diagnosis Form* AIDS Drug Assistance Program (ADAP)
4. Refer the client to an ADAP enrollment site using the site locator tool

## Health Plan In-Network Provider signature:

**Provider Signature:** ______________________________ **Date:** ______________________________