



Clinical Provider Application

Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

Complete all fields. Do not leave any fields blank. Enter "NA" if not applicable. Return by email to: PrEPSupport@cdph.ca.gov. Questions? Contact us at (844) 421-7050 (Monday – Friday, 8 a.m. – 5 p.m.)

1 Clinic or organization legal business name _____
[Use this link to verify your legal business name.](#) Print and attach verification **(required)**

2 Taxpayer Identification Number _____

3 Contract manager (contact for contract negotiations)
Full name _____ Title _____
Phone number _____
Email address _____

4 Medical billing contact (contact for medical coding or billing issues)
Full name _____ Title _____
Phone number _____
Email address _____

5 Authorized signatory (individual with authority to sign a contract on behalf of the clinic or organization)
Full name _____ Title _____
Mailing address _____
City _____ State _____ ZIP code _____
Phone number _____
Email address _____

6 PrEP-AP provider required services
The following services are recommended by the Centers for Disease Control (CDC) in the PrEP Clinical Guidelines. PrEP-AP network providers are required to provide all of the following medical services (onsite or through a contracted laboratory services provider)—
• HIV Testing • STI Testing (multi-site testing recommended) • Pregnancy Testing • Hepatitis B and C Testing
• Prescribe PrEP for the prevention of HIV • Creatinine Testing • Primary Care Services (related to PrEP)
Clinic can provide all PrEP-AP required services in-house..... Yes No

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7 Clinic will contract with an outside laboratory for lab services Yes No
If “Yes”,

- Complete—
 - *Worksheet 1: Lab Fee Costs (required)*
 - Attach a lab fee schedule obtained from your lab services contractor showing your contracted rates **(required)**
- **Note:** The PrEP-AP cannot reimburse laboratories directly. The contracted clinical provider must bill the PrEP-AP and payment will be remitted to the contracted clinical provider.

8 Clinic will provide mobile PrEP-related medical services Yes No
If “Yes”,

- Complete and attach *Worksheet 2: Transportation Plan for Mobile PrEP-related Medical Services (required)*

9 Clinic has multiple locations that will be joining the PrEP-AP Provider Network..... Yes No
If “Yes”,

- Complete and attach *Worksheet 3: Additional Clinical Locations (required)*

10 Associate providers

Please list the full name and National Provider Identifier (NPI) of all associate providers who will provide PrEP-related medical services and bill the PrEP-AP under the Taxpayer Identification Number identified on page one. If more space is needed attach an additional page.

Associate Provider Name	Associate Provider NPI
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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11 Clinic information

Group NPI _____

Clinic name _____

Clinic address _____

City _____ State _____ ZIP code _____

Phone number (for appointments) _____

Clinic location sees all patients regardless of coverage Yes No

Clinic location offers services in the following languages:

English Spanish Mandarin Vietnamese Tagalog

Other (specify) _____

Clinic provides HIV services Yes No

If “Yes”,

Can a new patient appointment be made within three business days for a patient with a new diagnosis of HIV? Yes No

Does the clinic have a rapid HIV treatment protocol for patients who want to initiate treatment immediately? Yes No

Clinic is a Federally Qualified Health Center Yes No

[Use this link to verify](#). **If “Yes”, print and attach verification (required)**

Clinic is an approved covered entity in the 340B Drug Pricing Program Yes No

[Use this link to verify](#). **If “Yes”, print and attach verification (required)**

Note: Clinic must be a 340B entity to join the PrEP-AP Provider Network

Clinic is contracted with Medi-Cal Yes No

Clinic has an onsite pharmacy Yes No

If “Yes”,

Is the pharmacy in the Medi-Cal pharmacy network? Yes No

Is the pharmacy in the Magellan Rx pharmacy network? Yes No

Clinic can bill Medicare Yes No

Clinic can bill private insurance health plans Yes No

If “Yes”,

Clinic can bill the following private insurance health plans (specify):

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Clinic information (continued)

Clinic can submit electronic claims to the PrEP-AP in 837P format Yes No

Clinic can submit paper claims to the PrEP-AP using [CMS form 1500](#) Yes No

Capacity to Provide Starter Packs

Please indicate if the clinic maintains onsite inventory of, or has immediate access to, the following PrEP and Post-Exposure Prophylaxis (PEP) prescription drugs:

Truvada® (tenofovir/emtricitabine)..... Yes No

Dolutegravir Yes No

Raltegravir Yes No

Rilpivirine Yes No

Is this clinic able to provide patients with 14-day starter packs of the PrEP or PEP medications listed above? Yes No

12 Affirmation and signature

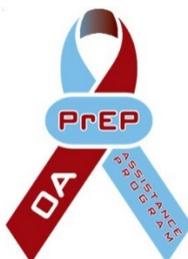
This section must be completed by the individual with authority to sign a contract on behalf of the clinic or organization. Electronic signatures are acceptable and preferred on this application. Please note: wet signatures are required on contract documents.

I hereby affirm that the information provided in this application, and in any documents attached to or submitted in conjunction with this application, is true, accurate, complete and, to the best of my knowledge and belief, is furnished in good faith.

Authorized Signatory Printed Name (First, Middle Initial, Last)

_____ Signature

_____ Date



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Worksheet 1: Lab Fee Costs

Complete this worksheet only if your clinic outsources for laboratory services. Providers who outsource for laboratory-related medical series will be reimbursed by the PrEP-AP at their negotiated rate as specified in the contract between the provider and laboratory services provider. Attach a copy of your lab fee schedule (**required**).

For services not covered by your lab services contract, input "NA" in the Contracted Rate field.

Clinic name _____

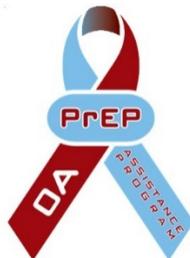
Date _____

CPT Code	Description	Contracted Rate	Performed Onsite	
HIV Testing				
86689	HTLV/HIV CONFIRMATORY TEST	\$	YES	NO
86701	HIV-1	\$	YES	NO
86702	HIV-2	\$	YES	NO
86703	HIV-1/HIV-2, SINGLE ASSAY	\$	YES	NO
87389	HIV-1/2 ANTIGEN AND ANTIBODIES, FOURTH GENERATION WITH REFLEXES	\$	YES	NO
87390	HIV-1 AG, EIA	\$	YES	NO
87391	HIV-2 AG, EIA	\$	YES	NO
87534	HIV-1, DNA, DIR PROBE	\$	YES	NO
87535	HIV-1, DNA, QUALITATIVE, PCR	\$	YES	NO
87536	HIV-1, DNA, QUANT	\$	YES	NO
87537	HIV-2, DNA, DIR PROBE	\$	YES	NO
87538	HIV-2, DNA, AMP PROBE	\$	YES	NO
87539	HIV-2, DNA, QUANT	\$	YES	NO
STI Testing				
86592	BLOOD SEROLOGY, QUALITATIVE	\$	YES	NO
86593	BLOOD SEROLOGY, QUANTITATIVE	\$	YES	NO
86780	TREPONEMA PALLIDUM PARTICLE AGGLUTINATION ASSAY	\$	YES	NO
87070	CULTURE, BACTERIA, OTHER	\$	YES	NO
87081	CULTURE	\$	YES	NO
87110	CHLAMYDIA, CULTURE	\$	YES	NO
87164	DARK FIELD WITHOUT SPECIMEN COLLECTION	\$	YES	NO
87166	DARK FIELD WITH SPECIMEN COLLECTION	\$	YES	NO
87205	SMEAR, GRAM STAIN	\$	YES	NO
87270	CHLAMYDIA TRACHOMATIS AG, IF	\$	YES	NO
87285	TREPONEM PALLIDUM AG, IF	\$	YES	NO
87320	CHLAMYDIA TRACHOMATIS AG, EIA	\$	YES	NO
87490	CHLAMYDIA TRACH, DNA, DIR PROBE	\$	YES	NO

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Worksheet 1: Lab Fee Costs (continued)

CPT Code	Description	Contracted Rate	Performed Onsite	
STI Testing (continued)				
87491	CHLAMYDIA TRACH, DNA, AMP PROBE	\$	YES	NO
87492	CHLAMYDIA DNA OR RNA, QUANT	\$	YES	NO
87590	N. GONORRHOEAE, DNA, DIR PROBE	\$	YES	NO
87591	N. GONORRHOEAE, DNA, AMP PROBE	\$	YES	NO
87592	N. GONORRHOEAE, DNA, QUANT	\$	YES	NO
87800	SMEAR, GRAM STAIN	\$	YES	NO
87801	MULTIPLE ORGANISM NAAT	\$	YES	NO
Pregnancy Testing				
81025	HCG, QUALITATIVE, URINE	\$	YES	NO
Renal Function Testing				
80053	COMPREHENSIVE METABOLIC PANEL	\$	YES	NO
82565	CREATININE, BLOOD	\$	YES	NO
Hepatitis A Screening				
86708	HAV AB	\$	YES	NO
Hepatitis B Screening				
80074	ACUTE HEPATITIS PANEL	\$	YES	NO
87340	HEPATITIS B SURFACE AG, EIA	\$	YES	NO
87341	HEPATITIS B SURFACE AG, EIA	\$	YES	NO
86704	HBV CORE AB	\$	YES	NO
86706	HBV SURFACE AB	\$	YES	NO
Hepatitis C Screening				
86803	HEPATITIS C AB TEST	\$	YES	NO
86804	HEPATITIS C AB TEST, CONFIRM	\$	YES	NO



**Clinical Provider Application
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**Worksheet 2: Transportation Plan
For PrEP-related Medical Services**

Complete this worksheet only if your clinic or organization will provide mobile PrEP-related medical services. Attach a copy of your organization's internal policies related to the transportation of personal and/or protected health information.

Clinic or organization legal name _____

Street address _____

City _____ State _____ ZIP Code _____

Mobile clinic days and hours of operation:

Monday Hours _____

Tuesday Hours _____

Wednesday Hours _____

Thursday Hours _____

Friday Hours _____

Saturday Hours _____

Sunday Hours _____

List the name/description and address of locations the mobile clinic will travel to:

Name/description _____

Street Address _____

City, State, ZIP _____

Name/description _____

Street Address _____

City, State, ZIP _____

Name/description _____

Street Address _____

City, State, ZIP _____

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Worksheet 2: Transportation Plan
For PrEP-related Medical Services (continued)

- The mobile unit routinely travels to an established location to provide clinical services..... Yes No
- The mobile unit travels to special events to provide clinical services..... Yes No
- The mobile unit provides services to the local homeless population..... Yes No
- The mobile unit provides clinical services in response to local emergencies..... Yes No
- The mobile unit is in use temporarily because the main clinic is currently not accessible to patients..... Yes No

The mobile clinic protects patient confidentiality by providing the following services privately inside the unit (select all that apply):

- | | | |
|------------------------|--------------------------------|---------------------|
| PrEP/PEP consultations | Vaccination services | Hepatitis screening |
| STI testing | HIV testing | Pregnancy testing |
| Follow-up appointments | Other services (specify) _____ | |

How will personal and/or protected health information be transferred, transmitted, and/or transported between the mobile unit and the main clinical location? (specify)

- Are paper documents secure at all times in accordance with State and Federal HIPAA requirements?..... Yes No
- Is electronic data securely encrypted?..... Yes No

Please provide a brief description of your clinic's policy related to the collection and transportation of personal and protected health information:

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**Worksheet 2: Transportation Plan
For PrEP-related Medical Services (continued)**

Office of AIDS Policy for Transporting Personal and Protected Health Information

It is the policy of the Office of AIDS to ensure that the personal health information of its clients will be safe, secure and protected in accordance with Office of AIDS confidentiality and security requirements for safeguarding the confidentiality of protected health information. To meet this policy requirement, any contracted PrEP-AP Clinical Provider that operates a mobile unit for the provision of clinical services to PrEP-AP clients will be required to implement reasonable and appropriate administrative, technical, and physical measures to safeguard all personal and protected health information from any intentional or unintentional use or disclosure that might violate any County, State or Federal privacy regulations.

Attestation

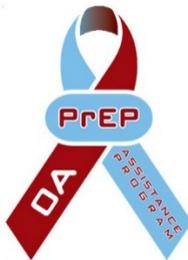
I attest that the information provided in this Transportation Plan related to the clinical mobile unit is, to the best of my knowledge, true and accurate. I agree to immediately notify the California Department of Public Health, Office of AIDS, of any breach in client personal or protected health information resulting from the operations of the mobile unit.

Printed Name of Authorized Signatory

Title

Signature

Date



**Clinical Provider Application
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Worksheet 3: Additional Clinic Location

If you have multiple clinic locations, complete one worksheet for each additional location

Additional Clinic Information

Group NPI _____

Clinic name _____

Clinic address _____

City _____ State _____ ZIP code _____

Phone number (for appointments) _____

Clinic location sees all patients regardless of coverage Yes No

Clinic location offers services in the following languages:

English Spanish Mandarin Vietnamese Tagalog

Other (specify) _____

Clinic provides HIV services Yes No

If “Yes”,

Can a new patient appointment be made within three business days for a patient with a new diagnosis of HIV? Yes No

Does the clinic have a rapid HIV treatment protocol for patients who want to initiate treatment immediately? Yes No

Clinic is a Federally Qualified Health Center Yes No

[Use this link to verify.](#) **If “Yes”, print and attach verification (required)**

Clinic is an approved covered entity in the 340B Drug Pricing Program Yes No

[Use this link to verify.](#) **If “Yes”, print and attach verification (required)**

Note: Clinic must be a 340B entity to join the PrEP-AP Provider Network

Clinic is contracted with Medi-Cal Yes No

Clinic has an onsite pharmacy Yes No

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Is the pharmacy in the Magellan Rx pharmacy network? Yes No

Clinic can bill Medicare Yes No

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Worksheet 3: Additional Clinic Location (continued)

Clinic can bill private insurance health plans..... Yes No

If “Yes”,

Clinic can bill the following private insurance health plans (specify):

Clinic can submit electronic claims to the PrEP-AP in 837P format Yes No

Clinic can submit paper claims to the PrEP-AP using [CMS form 1500](#) Yes No

Capacity to Provide Starter Packs

Please indicate if the clinic maintains onsite inventory of, or has immediate access to, the following PrEP and Post-Exposure Prophylaxis (PEP) prescription drugs:

Truvada® (tenofovir/emtricitabine)..... Yes No

Dolutegravir..... Yes No

Raltegravir..... Yes No

Rilpivirine..... Yes No

Is this clinic able to provide patients with 14-day starter packs of the PrEP or PEP medications listed above?..... Yes No

