



Provider Referral Form

Pre-Exposure Prophylaxis Assistance Program (PrEP-AP)

The client below is newly enrolled in 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. **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 see the [Allowable PrEP Related Medical Services](#) and [Allowable PrEP Related Clinically Administered Medications](#) 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 for PrEP related services for any reason. To receive payment for allowable PrEP-related services, please bill 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:
 - a. For **uninsured clients, clients with confidentiality concerns, and minor clients (12-17 years old)** use payer ID PAI01
 - b. For **insured clients** use 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

For uninsured clients, clients with confidentiality concerns, and minor clients, PrEP-AP will cover the full cost of PrEP-related services. For insured clients PrEP-AP will cover co-payments, co-insurance, and deductibles for PrEP-related services after the primary insurance has been billed.



Enrollment Worker complete the following:

Check here if the client is already enrolled in a pharmaceutical assistance program and does not require a clinical assessment to be prescribed PrEP

Client Name: _____ **PrEP-AP ID Number (optional):** _____

Enrollment Worker Name: _____ **Phone:** _____

Email: _____ **Fax:** _____

Name and address of agency client was referred to: _____

Client Type:

Uninsured:

Client *must* enroll into a patient assistance program to cover PrEP medications

Insured:

Client *may need to* enroll in a co-pay assistance program if insurance does not cover full cost of PrEP medications.

Confidentiality Concerns*:

Client does not need to enroll in any pharmaceutical assistance program

Minor (12-17 years old):

Client does not need to enroll in any pharmaceutical assistance program

Insured clients must visit a provider in their health plan’s network. Uninsured clients, clients with confidentiality concerns, and minor clients must visit a [PrEP-AP Clinical Provider](#).

*The client has insurance through a parent, spouse, or registered domestic partner, but cannot use their insurance due to confidentiality concerns.

Pharmaceutical Assistance Program:

The client does not need to enroll in a pharmaceutical assistance program

The client needs to enroll in the following pharmaceutical assistance program

Gilead Advancing Access® Patient Support Program (fully covers Truvada® and Descovy®)

Gilead Advancing Access® Co-payment Assistance Program (covers Truvada® and Descovy® co-payments)

Ready, Set, PrEP (fully covers Truvada® and Descovy®)

ViiVConnect® Patient Assistance Program (fully covers Apretude®)

ViiVConnect® Co-payment Assistance Program (covers Apretude® co-payments)

Other: _____

Clinical Provider must 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® Apretude® Other: _____

For HIV negative clients only, please fax this form to the enrollment worker identified above and complete and return any pharmaceutical assistance program application documents provided by the enrollment worker (some applications may need to be completed online).

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 another 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](#) to facilitate the client's enrollment into the AIDS Drug Assistance Program (ADAP)
4. Refer the client to an ADAP enrollment site using the [ADAP site locator tool](#) .

Clinical Provider Signature:

Signature: _____ **Date:** _____