# Provider Referral Form for Uninsured Clients

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

The client below is referred to you for a clinical assessment for PrEP as an HIV prevention measure in accordance with the terms of your PrEP-AP Provider Network Contract with the California Department of Public Health (CDPH). **The client is not to be billed for services for any reason**.

**PrEP-AP Providers**: 1) verify client enrollment in PrEP-AP prior to rendering services by calling the CDPH Call Center at (844) 421-7050, 2) complete the Provider section of this form, and 3) complete the Provider section of the client's Gilead Patient Assistance Program application.

### 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 ID Number:** _____

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

**Email:** _____ **Fax:** _____

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

_____

### Contracted PrEP-AP Provider complete the following:

**Provider Name:** _____ **NPI Number:** _____

Client is **HIV Negative** and clinically eligible for PrEP and will be prescribed: ☐ Truvada® ☐ Descovy®
**For HIV negative clients only**, please fax form and the complete Gilead application to the enrollment worker identified above. Please Note: If the client is enrolling into PREP as a minor due to confidentiality concerns, the client is **not** required to enroll in the Gilead Assistance Program.

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

1. If the client is a minor, please refer them to the Medi-Cal Minor Consent Program. The Medi-Cal Minor Consent Program is managed through local county offices. County listings can be found at www.dhcs.ca.gov/services/medi-cal/pages/countyoffices.aspx for further assistance.
2. If the client is insured but was enrolling into the PrEP-AP as uninsured due to confidentiality concerns and tests positive, the client will not be able to enroll in ADAP as uninsured. The client would have to utilize their health insurance.
3. 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 clinical care provider ideally with a same day appointment.
4. 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*

**Contracted PrEP-AP Provider complete the following:**

- ☐ 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):_____

5. Provide the client with this form and a completed *Diagnosis Form* to facilítate the client's enrollment into the AIDS Drug Assistance Program (ADAP)
6. Refer the client to an ADAP enrollment site using the site locator tool.

**Provider Signature**: _____ **Date**: _____