Provider Referral Form for Kaiser Clients Only
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 a possible secondary payer source after the client's primary insurance coverage.

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 www.cdph.ca.gov/PrEP-AP/Resources for 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 client directly or 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: 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:

Client Name: _____ **PrEP-AP ID Number:** _____

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

Email: _____ **Fax:** _____

Name and address of agency client was referred to: _____

_____

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 this form and the completed Gilead application to the enrollment worker

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 Document2019-02: 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* to facilitate the client's enrollment into the AIDS Drug Assistance Program (ADAP)
4. Refer the client to an ADAP enrollment site using the site locator tool.

Provider Signature:_____ **Date:**_____