State of California-Health and Human Services Agency

California Department of Public Health

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 if applicable (minors & clients with confidentiality concerns do not need to enroll in the Gilead Patient Assistance Program).

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: _____

_____

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® ◯ Generic TDF/FTC ◯ Descovy®

To ensure medication coverage, uninsured clients and Medicare clients without Part D Coverage should be prescribed Truvada® or Descovy®. Minor clients, and clients with confidentiality concerns should be prescribed Generic TDF/FTC, unless Descovy® is clinically indicated; if prescribing Descovy®, write the prescription as Dispense as Written.

For HIV negative clients only, please fax this form and the completed Gilead application to the enrollment worker identified above. Please Note: If the client is enrolling into PrEP as a minor, or as uninsured due to confidentiality concerns, the client is **not** required to enroll in the Gilead Assistance Program.

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☐ 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 the Department of Health Care Services County Offices (https://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 into 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*
   - ◯ 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 facilitate 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.

Contracted PrEP-AP Provider signature:

Provider Signature:_____ **Date:**_____