Maryland Governor's Office of Crime Prevention, Youth, and Victim Services
Sexual Assault Reimbursement Unit (SARU)
100 Community Place, Crownsville, MD 21032

nPEP/HIV Prophylaxis Treatment Reimbursement Claim & Prescription Form

This form is to be submitted with an itemized bill, SARU SAFE Reimbursement Form, and UB-04 CMS-1450 or OMB-0938-1197 1500 form. Submit mandatory forms for reimbursement to the Sexual Assault Reimbursement Unit (SARU) within 90 days of the exam. Reimbursement claims are subject to the guidelines of the SARU. All fields must be completed. Please provide a remittance address if it is different from the facility address.

Patient Information

Patient's Full Name:____
(Last) (First) (Middle)

Patient's DOB: ____________________ **Patient Medical Record Number:** ____________________
(mm/dd/yy)

Patient Age: ____________________ **Patient Race:** ____________________

Patient Gender: ☐ Male ☐ Female ☐Transgender ☐ Other: ____________________

Patient's Address: ____
(County) (Zip Code)

Delivery Address: ____
(If applicable) (Address) (City) (State) (Zip Code)

Date & Time of Sexually-Based or Sexually Related Crime: ____________________
(mm/dd/yy) (Approximate Time)(AM/PM)

Location of Sexually-Based or Sexually Related Crime: ____________________
(City/County/State)

Date and Time of Forensic Exam, if applicable: ____________________
(mm/dd/yy) (Approximate Time) (AM/PM)

(A "sexually-based assault" includes any rape, sexual assault, or sexual child abuse as outlined in Maryland Criminal Law Articles 3-303 through 3-308).

Healthcare Facility Information

Healthcare Facility Providing HIV Exposure Assessment & Treatment:
____

Facility Phone Number: ____________________ **Facility Fax:** ____________________

Billing Email Address: ____

Appointment Type: ☐ Initial Examination ☐ Follow Up Care

Patient Name: ____

nPEP/HIV Prophylaxis Treatment Authorization

I hereby authorize ____________________________________ and _________________________________
(Hospital/Healthcare Facility) (Qualified Healthcare Professional/Examiner)

to conduct an assessment of HIV exposure risk in accordance with current guidelines. Additional medical assessment and treatment may include a sexual assault forensic exam to gather information and evidence as to an alleged sexual assault.

In addition, I hereby authorize the transmittal of the below list of forensic medical services and treatment rendered to me to the Criminal Injuries Compensation Board's Sexual Assault Reimbursement Unit (SARU) for the purpose of providing authority for the SARU to pay the physician, qualified healthcare provider, or hospital for the services rendered to me, including nPEP/HIV prophylaxis. I understand that I do not have to obtain a full Sexual Assault Forensic Exam (SAFE) in order to access the full course of nPEP/HIV prophylaxis treatment. Additionally, I understand that my personal information, including my medical chart, narrative of the assault, and photographs/video will not be disclosed as a requirement for the qualified healthcare provider to obtain reimbursement.

Signed:____
(Print Name) (Signature)

Relationship to patient: ___________________________________ Date: __________________________
(self, guardian, authorized surrogate) (mm/dd/yy)

nPEP/HIV Prophylaxis Reimbursement Form Continued

Patient Name: ____

Sexual Assault Forensic Exam Information

Did the patient receive nPEP treatment **without** having a SAFE exam? □Yes □ No
If patient received a SAFE, Date of SAFE: ______________________ (mm/dd/yy)
Hospital where the patient received SAFE: ____

Required Data

Was the patient assessed for exposure to HIV? □ Yes □ No
Did the patient qualify to receive nPEP? □ Yes □ No
Did the patient choose to receive nPEP? □ Yes □ No
Was a follow-up care referral made? □ Yes □ No
If yes, where: ____
Which payment option will be utilized for billing?

- □ Sexual Assault Reimbursement Unit
- □ Pharmaceutical patient assistance program
- □ Public/Private Health Insurance

If public/private health insurance is utilized, which insurance company? ____

Laboratory Services

□ Pregnancy Test (Qualitative): □ Serum □ Urine
□ HIV rapid antigen/antibody
□ CBC
□ CMP
□ Hepatitis B (HBV) serology □ Hep b surface antigen □ Hep b surface antibody □ Hep b core antibody
□ Hepatitis C (HCV) antibody
□ Syphilis serology
□ Gonorrhea
□ Chlamydia
□ Other ____

nPEP/HIV Prophylaxis Reimbursement Form Continued

Patient Name: ____ Date: ________________________

Patient DOB: ________________________ Patient Phone #: ______________________________________

Patient Weight: __________ lbs Allergies: ____

nPEP Medication Regimen

Number of days/doses of nPEP medication provided at facility: ☐ 1 ☐ 3 ☐ 5 ☐ 7 ☐ 28
☐ Other: ____

If less than a full 28-day regimen was supplied, where was the patient referred to obtain the balance of treatment?
☐ Retail Pharmacy ☐ Health Department ☐ Hospital Pharmacy ☐ HIV/Immunology Clinic
☐ Other ____

CDC Recommended Regimens (2016):

The National Clinician Consultation Center offers free non-occupational post-exposure prophylaxis consultation Mon-Fri 9 am to 8 pm EST and weekend and holidays 11 am to 8 pm. Call 888-448-4911 for more information.

☐ **Otherwise healthy adults and adolescents ≥ 13-years old**: A 3-drug regimen of Truvada + Isentress OR Tivicay
☐ **Adults and adolescents ≥ 13-years old with renal dysfunction (creatinine clearance <59 mL/min):** A 3-drug regimen of Combivir + Isentress OR Tivicay (dosages adjusted to degree of renal function)
☐ **Children age 2-12 years old**: A 3-drug regimen of tenofovir DF, emtricitabine, and raltegravir, with dosages adjusted to age and weight
☐ **Children age 4 weeks – 2 years old**: A 3-drug regimen of zidovudine, lamivudine, and raltegravir or lopinavir/ritonavir with dosages adjusted to age and weight

Please check orders to be used:

☐ **Truvada** (emtricitabine 200 mg and tenofvir DF 300 mg) – 1 tablet daily
☐ **Isentress** (raltegravir 400 mg) – 1 tablet twice a day
☐ **Tivicay** (dolutegravir 50 mg) – 1 tablet daily (Avoid during first trimester or for women of child-bearing age)
☐ **Combivir** (zidovudine 300 mg and lamivudine 150 mg) – 1 tablet twice a day
☐ Stribild (EVG/COBI/FTC/TAF)
☐ Ondansetron (Zofran)
☐ Other: ____

Was a follow-up care referral made? ☐ Yes ☐ No
If yes, provide referral location: ____

Provider Name: ___________________________________ NPI: ______________________________

Provider Signature: ________________________________ Phone #: ___________________________

Medical Services

☐ Physician/Qualified Healthcare Provider
☐ Other medical:
____