Maryland
GOVERNOR'S OFFICE OF CRIME PREVENTION AND POLICY

Sexual Assault Reimbursement Unit (SARU): SAFE Reimbursement Form (SSRF)

Authorization for Sexual Assault Forensic Medical Examination

Submit this completed form with an itemized bill and UB-04, CMS-1450, or OMB-0938-1197 1500 form to the SARU within 90 days of exam. Reimbursement is subject to SARU regulations and guidelines. Provide a remittance address if different from facility address.

## Healthcare Facility Information

| | |
|---|---|
| Facility Name: | |
| Healthcare Professional Conducting Examination: | |
| Phone #: | Billing Email: |
| Appointment Type: | |
| Bill Type: | |

## Patient Information

| | | |
|---|---|---|
| Name: | | *(Last, middle, first)* |
| DOB: | Age: | |
| Race: | Ethnicity: | Gender: |
| City of Residence: | County of Residence: | |
| Medical Record #: | | |

## Crime Information

| | | |
|---|---|---|
| Date and Time: | County: | |
| Police Department Contacted: | | |
| Officer Name: | | |
| Badge #: | District: | Phone #: |
| Case #, Property Held #, or Other Identifier: | | |

## Patient Authorization for Examination, Collection or Storage of Evidence, and Release of Information

*Instructions: Please read the entire Authorization packet before signing this form.*

I hereby authorize _____ and _____ to
(Hospital) (Qualified Healthcare Professional/Examiner)
conduct a medical evaluation and/or treatment, which may include a sexual assault forensic exam to gather information and evidence as to an alleged sexual assault, including the collection of blood, urine, tissue, or other specimens and clothing and the taking of photographs and/or video.

In addition, I hereby authorize the transmittal of the below list of forensic medical services and treatment rendered to me to the Sexual Assault Reimbursement Unit (SARU) to provide the authority for the SARU to pay the physician, qualified healthcare provider or hospital for the services rendered to me and for the collection of evidence. I understand that my personal information, including my medical chart, narrative of the assault, and photographs/video, cannot be disclosed as a requirement to obtain reimbursement pursuant to Criminal Proceedings §11-1007.

Furthermore, I authorize the hospital or medical provider to share records of the forensic medical services and treatment I received to the police department of the jurisdiction where the alleged crime took place if I choose to report it to the police and to the Office of the State's Attorney of the jurisdiction, if I choose to participate in a prosecution of the alleged sexual assault.

(Print Name) (Signature or e-Signature)

Relationship to patient:

Date (mm/dd/yy)

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## Drug-Facilitated Sexual Assault Testing

*Instructions: Please complete this section if there is suspicion of drug-facilitated sexual assault warranting additional testing.*

By signing below, I authorize the provider to collect blood and/or urine specimens to identify the presence of drugs possibly involved in a sexual assault. I understand that this evidence will be provided to law enforcement and a State's Attorney if I choose to report the crime. I understand that I may refuse this testing.

_____
(Print Name) (Signature or e-Signature)

Relationship to patient:

_____
Date (mm/dd/yy)

## Medical Services

☐ Medical Screening Exam ☐ Forensic Exam ☐ Radiology ☐ Surgical Consult

Other Medical Services:

◯ None ◯ Yes (please list each service or write NA): _____

_____

## Laboratory Services

**Blood Panels:** ☐ CBC ☐ CMP ☐ Serum Alcohol Other:

**Pregnancy Test:** ☐ Serum ☐ Urine

***Note**: SARU will only reimburse qualitative pregnancy tests.*

Other Lab Service:

## Sexually Transmitted Infections

☐ Genital culture

☐ Urine NAAT

☐ Rectal culture

Gonorrhea: Chlamydia:

☐ Oral ☐

☐ Vaginal ☐

☐ Rectal ☐

☐ Wet prep

☐ Herpes culture

☐ Trichomoniasis

☐ RPR, VDRL, Syphilis

☐ Hepatitis panel

☐ HIV antigen/antibody

## Toxicology Screen Services

☐ Standard hospital 12-panel toxicology screening ☐ Outsourced toxicology panel (include a complete invoice)

***Drug-Facilitated Sexual Assault***

Did the provider order toxicology screening to establish the presence of drugs that may have facilitated the sexual assault?

◯ No ◯ Yes (if yes, please complete the fields below)

Type of sample:

☐ **Blood**
Date and time collected: _____
Date and approximate time of suspected ingestion of drugs: _____

☐ **Urine**
Date and time collected: _____
Date and approximate time of suspected ingestion: _____

***Notes***:

- Please find the SARU's DFSA guidelines at gocpp.maryland.gov/victim-services/saru/.
- SARU will reimburse for blood sample testing if the sample is collected within 24 hours of suspected ingestion and for urine sample testing if the sample is collected within 120 hours of suspected ingestion.

## Medications Administered for Reimbursement

**Emergency Contraception:** ◯ Yes ◯ No

**Pain Medication:** ☐ Tylenol (Acetaminophen) ☐ Motrin (Ibuprofen) ☐ Ketorolac ☐ Lidocaine Other:

**Antibiotics:**

☐ Rocephin (Ceftriaxone) ☐ Flagyl (Metronidazole) ☐ Erythromycin ☐ Levaquin (Levafloxacin)

☐ Zithromax (Azithromycin) ☐ Suprax (Cefixime) ☐ Cipro (Ciprofloxacin) ☐ Doxycycline

**Vaccines:** ☐ Tetanus **Anti-nausea:** ☐ Zofran (Ondansetron)

**Other:**

**HIV Prophylaxis**:

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

Did the patient elect to receive nPEP treatment without a SAFE exam? ◯ Yes ◯ No

Was an HIV follow-up care referral made? ◯ Yes ◯ No

If yes, where: _____

# days/doses of nPEP provided at facility:

If other, please specify # of doses: _____

If the facility provided less than a full 28-day regimen, where did the provider refer the patient to obtain the balance of treatment?

If other, please specify: _____

If the provider referred the patient to Altruix Pharmacy, please complete the nPEP/HIV Prophylaxis Reimbursement Claim & Prescription form (it begins on page 5). Then, send the completed form to meds@altruix.com or 877-829-1935 (fax).

**CDC Recommended Regimens (2016):**

The National Clinician Consultation Center offers free PEP consultations Monday through Friday, 9 a.m. to 8 p.m. EST, and on weekends and holidays, 11 a.m. to 8 p.m. Call 888-448-4911.

- **Healthy patients 13 years old and older:** 3-drug regimen of Truvada + Isentress OR Tivicay
- **Patients 13 years old and older with renal dysfunction (creatinine clearance <59 mL/min):** 3-drug regimen of Combivir + Isentress OR Tivicay (dosages adjusted to degree of renal function)
- **Patients 2-12 years old:** 3-drug regimen of Tenofovir DF, Emtricitabine, and Raltegravir, with dosages adjusted to age and weight
- **4 weeks-2 years old:** 3-drug regimen of Zidovudine, Lamivudine, and Raltegravir OR Lopinavir/Ritonavir with dosages adjusted to age and weight

**Check orders to be used:**

☐ Truvada (Emtricitabine 200 mg and Tenofovir DF 300 mg)
☐ Isentress (Raltegravir 400 mg)
☐ Tivicay (Dolutegravir 50 mg)
(Avoid during first trimester or for women of childbearing age)
☐ Combivir (Zidovudine 300 mg and Lamivudine 150 mg)
☐ Stribild (Elvitegravir 150mg, Cobicistat 150mg, Emtricitabine 200mg and Tenofovir 300mg)
☐ Zofran (Ondansetron 4mg ODT)
☐ Other: _____

# Certification of Sexual Assault Treatment to Validate Reimbursement

I hereby attest and affirm to the best of my knowledge that _____ (Patient's full name) was treated for alleged rape, sexual assault, or child sexual abuse or injuries sustained as a result in accordance with COMAR 10.12.02.5.I certify that any items billed to the SARU for reimbursement are for the treatment of alleged rape, sexual assault, or child sexual abuse including injuries sustained as a result.

_____

Print Name of Qualified Healthcare Provider (Signature or e-Signature)

Date:

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Sexual Assault Reimbursement Unit (SARU)

# nPEP/HIV Prophylaxis Treatment Reimbursement Claim & Prescription Form

Upon discharge, facilities should provide the patient with at least a 3 7-day dose of nPEP medication. If your facility cannot provide a full course of therapy at the time of discharge, send this completed form to meds@altruix.com or 877 829 1935 (fax). Altruix Pharmacy will provide the remaining medication to the patient by mail or courier.

*Even if you are only conducting an HIV exposure assessment and providing nPEP, please ensure you submit completed and signed pages 2 and 5*

Date: _____

Patient Name: _____
(Last) (First) (Middle)

DOB: _____ Phone #: _____

Delivery Address: _____
(Street) (City) (State) (Zip Code)

Patient Weight: _____ Allergies: _____

## nPEP Medication Regimen

Number of days/doses of nPEP medication provided at facility:

Other: _____

Check orders to be used:

- ☐ Truvada (Emtricitabine 200 mg and Tenofovir DF 300 mg)
- ☐ Isentress (Raltegravir 400 mg)
- ☐ Tivicay (Dolutegravir 50 mg)
  (Avoid during first trimester or for women of childbearing age)
- ☐ Combivir (Zidovudine 300 mg and Lamivudine 150 mg)
- ☐ Stribild (Elvitegravir 150mg, Cobicistat 150mg, Emtricitabine 200mg and Tenofovir 300mg)
- ☐ Zofran (Ondansetron 4mg ODT)
- ☐ Other: _____

Was a follow-up care referral made? ◉ No ○ Yes. Referral Location: _____

Provider Name: _____ NPI#: _____

Healthcare Facility: _____ Fax: _____

Provider Signature: _____ Phone #: _____
*(e-Signature accepted)*