



**Treatment Exception Request for CA ADAP
FOR PROVIDER USE ONLY**

(Please Print Clearly)

Phone: 888-311-7632 Fax: 800-848-4241

***PATIENT INFORMATION:**

LAST NAME FIRST NAME

Patient's ADAP ID Date of Birth

Most Recent Viral Load test/date: _____

Most Recent CD4 Count/date: _____

Current Weight: _____ Current Height: _____

Previous Weight: _____ Date: _____

***DIAGNOSIS DESCRIPTION:
(ICD-9 CM Code Plus Description)**

***MEDICAL JUSTIFICATION:**

***PHARMACY INFORMATION:**

Pharmacy Name NABP#

Phone Number Fax Number

***PHYSICIAN INFORMATION:**

Last Name First Name

Phone Number Fax Number

DEA Number E-Mail address

Address City Zip Code

*
Signature of pharmacist or physician Date

DRUGS REQUESTED (ADAP FORMULARY MEDICATIONS ONLY):

GENERIC NAME	NDC CODE	DIRECTIONS	QUANTITY

REQUEST: APPROVED AS REQUESTED APPROVED AS MODIFIED DENIED

COMMENTS:

AUTHORIZATION VALID FROM: ___/___/___ TO ___/___/___ BY: _____ DATE: _____

LONG TERM AUTHORIZATION PRIOR AUTHORIZATION REQUIRED FOR EACH FILL

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ADAP ELIGIBILITY. VERIFY PATIENT'S ELIGIBILITY PRIOR TO DISPENSING DRUG.

P H A R M A C Y U S E O N L Y