ALABAMA DRUG ASSISTANCE PROGRAM
Application Form

ADAP ID Number ____ - ____

○ Application
○ Recertification
○ Revision

Form Date __ / __ / ____

Recertification Date __ / __ / ____

Received Date __ / __ / ____

Date Processed __ / __ / ____

Revision Reason:

○ Compliance Issues ○ Intolerable Side Effects ○ Other Reason

○ Drug Interactions ○ Development of Resistance

PATIENT INFORMATION

Client First Name | Client Middle Name

Client Last Name | Home Phone

Address | Work Phone

City | Zip Code

County of Residence | Date of Birth

Social Security No. ___ - __ - ____

Client Sex: ○ Male ○ Female

Client Race: W ○ B ○ H ○ A ○ I ○ U

PHYSICIAN INFORMATION

Physician First Name | MI | Physician Last Name

Physician Address | Clinic Fax Number

Clinic Name | Clinic Phone

Clinic Address | City | Zip Code

Case Manager First Name | MI | Case Manager Last Name

CLINIC INFORMATION

Western Blot Test Results

☐ React ☐ Non-React

Date of Test __ / __ / ____

LOCATION (Facility, City, State) ☐ Same As Clinic

CD4 Cell Count

Date of Test __ / __ / ____

LOCATION (Facility, City, State) ☐ Same As Clinic

Latest Viral Load Results

Date of Test __ / __ / ____

LOCATION (Facility, City, State) ☐ Same As Clinic

How was client referred to you? ○ Title II ○ Title III ○ Title IV ○ Literature ○ Other_____

30675

ADAP ID Number ____ - ____

Client Pregnancy

Is client pregnant? ○ YES ○ NO

Expected Date of Delivery __/__/____

Is client a newborn of an HIV infected woman? (less than 6 weeks of age) ○ YES ○ NO

Mother's First Name

Mother's Last Name

Mother's Date of Birth __/__/____

PRIMARY EXPOSURE CATEGORY

(Check all that apply)

○ Blood Transfusion Prior to 1995 ○ Heterosexual ○ Homosexual ○ Hemophiliac
○ Occupational Exposure ○ IVDU ○ Perinatal Exposure ○ Unknown

FINANCIAL INFORMATION

MONTHLY GROSS INCOME: Earnings, Social Security, Pension, other checks or cash received

NO. Family Members in Household (Including Client) ____

Client Income $__,___

Family Members in Household Income $__,___

Combined Income From All Sources $__,___

INSURANCE INFORMATION

MEDICAID SUPPLEMENTAL SECURITY INCOME

Application Date __/__/____

Benefits Start Date __/__/____

Current Benefits $__,___.__

Medicaid Number

MEDICARE SUPPLEMENTAL SECURITY INCOME

Application Date __/__/____

Benefits Start Date __/__/____

Current Benefits $__,___.__

Percentage Drug Cost Covered ___%

Medicare Number

Medical Insurance Benefits

Medical Insurance Carrier

Effective Date __/__/____

Policy Number

Percentage Drug Cost Covered ___% In Force ☐

ALL KIDS Application Date __/__/____

ALL KIDS Eligibility Benefits Start Date __/__/____

VA ELIGIBILITY

Benefits Start Date __/__/____

Did you first enlist after September 7, 1980?
○ YES ○ NO

Did you ever serve in the Air Force, Army, Coast Guard, Marines, Navy or Reserves?
○ YES ○ NO

If yes, was your discharge?
○ Honorable ○ Dishonorable ○ Undesirable ○ Hardship
○ General ○ Bad Conduct ○ Disability ○ Other

If yes, length of service?
○ Less than 6 months ○ Over 6 months
○ Less than two years ○ Over two years

Form Completed By:

Date Completed __/__/____

First Name

Last Name

MAIL TO:

Alabama Department of Public Health
The RSA Tower, Suite 1400
HIV/AIDS Division, Direct Care Branch
PO BOX 303017
Montgomery, AL 36130-3017
ATTN: ADAP
Phone: (800)344-1153 or (334)206-5364
Fax: (888)476-4892
Mark envelope: CONFIDENTIAL

STATUS

Status Date __/__/____

○ Approved - Active ○ Inactive
○ Approved - Waiting ○ Denied
○ Approved - Pending

30675

ALABAMA DRUG ASSISTANCE PROGRAM
Program Medication Request

ADAP ID Number ____ - ____

All prescriptions will be filled with a 30 day supply of medication and will be active for **ONE YEAR** unless a revision is made. Generic meds will be dispensed unless Brand name meds are medically necessary. **CHECK ALL MEDICATIONS FOR WHICH ASSISTANCE IS REQUESTED, INCLUDING CURRENTLY PRESCRIBED MEDICATIONS. MUST HAVE PATIENT'S NAME & ID NO. ON THIS PAGE.**

Client First Name

Client Middle Name

Client Last Name

****Pre-Approval required for Procrit & Fuzeon**
Fuzeon needs CD4 & Resistance test verification)

	Dosage	Unit	Frequency
☐ Zidovudine (AZT,Retrovir)			
☐ Didanosine (DDI,Videx) EC			
☐ Stavudine (D4T,Zerit)			
☐ Lamivudine (3TC,Epivir)			
☐ Combivir (counts as 2 drugs)			
☐ Ziagen (Abacavir Sulfate)			
☐ Tenofovir (Viread)			
☐ Trizivir (Retrovir/Epivir/Ziagen)			
☐ Emtriva			
☐ Kaletra (counts as 2 drugs)			
☐ Ritonovir (Norvir)			
☐ Saquinavir (Invirase)			
☐ Indinavir (Crixivan)			
☐ Nelfinavir (Viracept)			
☐ Lexiva (Fosamprenavir calcium)			
☐ Truvada (Emtricitabine\Tenofovir)			
☐ Ethambutol			
☐ Epzicom (Abacavir Sulfate) (Lamivudine)			
☐ Atazanavir (Reyataz)			

	Dosage	Unit	Frequency
☐ Nevirapine (Viramune)			
☐ Efavirenz (Sustiva)			
☐ Fluconazole (Diflucan)			
☐ SMX/TMP DS			
☐ Bactrim DS			
☐ Acyclovir			
☐ Leucovorin			
☐ Dapsone			
☐ Valcyte			
☐ Zithromax			
☐ Azithromycin (Zithromax)			
☐ Sporanox (Itraconazole)			
☐ Epoetin alfa (Procrit)**			
☐ Fuzeon** (T-20 or enfurvitide)			
☐ Aptivus (Tipranavir)			
☐ Rifabutin			
☐ Prezista			
☐ Atripla			

Physician Information

I CERTIFY THAT THIS CLIENT IS PRESENTLY UNDER MY CARE FOR HIV/ AIDS AND THAT I PRESCRIBED THE MEDICATION(S) INDICATED ON THIS FORM FOR TREATMENT OF HIS/ HER CONDITION. I FURTHER CERTIFY THAT THE INFORMATION STATED ON THIS APPLICATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE

License Number

Date of Physician Signature

__ __ / __ __ / __ __ __ __

Physician Signature: _____

*FILL IN clinic address where medications will be sent.
MUST BE FILLED IN

30675

ADAP ID Number

All prescriptions will be filled with a 30 day supply of medication and will be active for **ONE YEAR** unless a revision is made. Generic meds will be dispensed unless Brand name meds are medically necessary. **CHECK ALL MEDICATIONS FOR WHICH ASSISTANCE IS REQUESTED, INCLUDING CURRENTLY PRESCRIBED MEDICATIONS. MUST HAVE PATIENT'S NAME & ID NO. ON THIS PAGE.**

Client First Name

Client Middle Name

Client Last Name

Only HIV drugs on ADAP formulary may be submitted. (See ADAP web site for approved formulary.)

Check box to add prescription		Write Name of Drug in Box Below	Dosage	Unit	Frequency
☐	Other Medication 1				
☐	Other Medication 2				
☐	Other Medication 3				
☐	Other Medication 4				

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License Number

Date of Physician Signature

/ /

Physician Signature: _____

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MUST BE FILLED IN

Revised June 27, 2007

30675