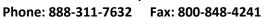


## TREATMENT EXCEPTION REQUEST

## Oregon CAREAssist

## FOR PROVIDER USE ONLY (PLEASE PRINT CLEARLY)





*PATIENT INFORMATION:		*PHARMACY INFORMATION:			
LAST NAME F	IRST NAME	Pharmacy Name	NABP#		
Patient's ADAP ID	Date of Birth	Phone Number	Fax Num	Fax Number	
Most Recent Viral Load test/date:		*PHYSICIAN INFORMATION:			
Most Recent CD4 Count/date:					
Current Weight:	Current Height:	Last Name	First Name		
Previous Weight:	Date:	Phone Number	Fax Numbe	Fax Number	
		DEA Number	E-Mail addre	255	
*DIAGNOSIS DESCRIPTION: (ICD-9 CM Code Plus Description)		Address	City	Zip Code	
*MEDICAL JUSTIFICATION:		* Signature of pharmacist or physician Date			
DRUGS REQUESTED (ADAP I	FORMULARY MEDICATIONS ONLY):				
GENERIC NAME	NDC CODE	DIRECTIONS	QUANT	TITY	
REQUEST: †APPROVED AS R COMMENTS:	EQUESTED †APPROVED AS MODIF	IED †DENIED			
PUBLIC HEALTH RX USE ONLY					
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. BE SURE  PATIENT'S ELIGIBILITY IS CURRENT BEFORE DISPENSING DRUG.					