# TREATMENT EXCEPTION REQUEST

## Oregon *CARE*Assist

**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:

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.