Print Form

ILLINOIS Department of Public Health

Ryan White Part B Program

Medication Assistance Program (MAP)

Pre-Approval for VALCYTE

TELEPHONE: 888-311-7685 FAX: 800-848-4241

Ramsell

Prescriptions for VALCYTE (valganciclovir hydrochloride) are only available with pre-approval through the Medication Assistance Program. You can click on the name of the medication to be taken directly to the specific prescribing guidelines. **NOTE:** There is a limit of 35 clients that can be approved for assistance with Valcyte at any given time. Physicians will be notified is applicant is approved.

To be eligible for this pre-approval, a client must meet all of the following:

- Be currently enrolled in MAP and eligible for MAP assistance
- Have been denied medication coverage by their insurance plan (if applicable). Documentation of denial must be provided.
- Meet one of the following:
  - ○ Be prescribed oral Valcyte™ for induction or maintenance treatment of cytomegalovirus (CMV) retinitis that has been diagnosed by an ophthalmologist and be under the care of an ophthalmologist. Documentation must be provided.
  - ○ Have a condition other than retinitis that is documented to be due to CMV for which use of VALCYTE is approved by the ADAP/MAP program based on review of medical records.

First Name	Middle Initial	Last Name
Member ID:	**Date of Birth**	**RW ID (if known)**

Indicate drug name, form and strength requested	Quantity requested:	Day supply:

Most Current CD4 Count	
	Patients with a sustained (6 month) increase in CD4 counts above 100 cells/µL in response to antiretroviral therapy **ALSO** require consultative note from an ophthalmologist indicating that Valcyte™ (valganciclovir hydrochloride) therapy continues to be recommended.
Has client been diagnosed with CMV Retinitis?	**Ophthalmologist diagnosing CMV Retinitis (print)**
☐ YES ☐ NO	

Provider must acknowledge the following with initials:

_____ I have reviewed the prescribing guidelines for possible interactions and issues of the medication regimen.

_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen.

Date:	**To the best of my knowledge, I certify that the above is accurate and true.**	
Provider Name (Print)	Provider Signature	
Clinic Name:	Phone #	Fax #
Pharmacy Name	Pharmacy Phone #	Fax #
REQUIRED DOCUMENTATION - Please check off and submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation will delay decision process.		
☐ Denied medication coverage by insurance plan (if applicable) ☐ Recent CD4 <500 (within the last 6 months) ☐ Consultative note from ophthalmologist		

Submit: Please fax completed application to Ramsell at **800-848-4241**.
For additional information, call the Ramsell Help Desk at: 1-888-311-7685.