# TREATMENT EXCEPTION REQUEST

**California 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 (extra pages may be attached if necessary, please be specific):**

_____
_____
_____
_____
_____

***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**

**PHRx USE ONLY**

**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. BE SURE PATIENT'S ELIGIBILITY IS CURRENT BEFORE DISPENSING DRUG.**