VIRGINIA DEPARTMENT OF HEALTH
ADAP MEDICATION EXCEPTION FORM

PATIENT NAME (Last, First, MI):			
D.O.B. (mm/dd/yy):	**AGE:**	**SEX:** ☐ **MALE**	☐ **FEMALE**
ADDRESS	**CITY**	**STATE**	**ZIP**
RACE/ETHNICITY: ☐ White (non-Hispanic) ☐ African American/Black (non-Hispanic) ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian, Aleutian, Eskimo ☐ Unknown			
HEALTH DEPARTMENT PHONE #		**HEALTH DEPARTMENT FAX #**	
LOCAL HEALTH DEPARTMENT ADAP CONTACT PERSON:			
PRESCRIBING PHYSICIAN NAME:			
PHYSICIAN PHONE #:		**PHYSICIAN FAX #:**	
FORM COMPLETED BY (Name):			
TITLE:		**DATE (mm/dd/yy):**	

MEDICATION REQUESTED:
REASON FOR EXCEPTION REQUEST (PLEASE REFER TO EXCEPTION CRITERIA):

Specify other anti-retroviral medications patient is currently on

NAME OF MEDICATION	DOSE	DATE STARTED	DATE DISCONTINUED

LABORATORY HISTORY [Please start with the most current results (give at least two (2) results if available)]

VIRAL LOAD RESULTS*	DATE	CD4 COUNT RESULTS	DATE

VDH USE ONLY

☐ **Request Approved** ☐ **Request Denied**

Rationale:_____

_____

Signature:_____ **Date:**_____

Date of Positive CCR5 assay/Maraviroc Approval: _____

Fax to: Central ADAP office at (804) 864-8050 [Phone: (855) 362-0658]

Revised 09/2012

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment