Virginia ADAP-Assist
CLAIMS AUTHORIZATION REQUEST FORM
Version 8.1

Provider Services: 888-311-7632
Fax Form to: 800-848-4241
or 510-587-2799

*PLEASE REVIEW REQUEST FOR ACCURACY AND COMPLETE ALL APPROPRIATE FIELDS! **To be completed by the Pharmacy***

PHARMACY INFORMATION

NPI: _____

CONTACT PERSON: _____
STAMP or **WRITE** Pharmacy Name, Phone & Fax:

PHONE: ( ) _____

FAX: ( ) _____

CLIENT INFORMATION
(Print Clearly)

_____
Last Name First Name

I.D.: _____

D.O. B. _____ / _____ / _____

All Claims over 235 days will be denied.

			Copay or Cash Price	Requested QTY	Days Supply	OCC	Prescription Date*
RX#1	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#2	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#3	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#4	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#5	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#6	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#7	_____	NDC : _____-_____-_____	$: _____		_____		_____
RX#8	_____	NDC : _____-_____-_____	$: _____		_____		_____

MUST CHECK ALL THAT APPLY!

Plan Limit

☐ ARV Daily QTY Max***Submit w/Treatment Exception Request (TER) form*

☐ Day supply ___ with copay

Clinical Limits

☐ ARV Duplicate Therapy
** *Include medical justification on Notes/Explanation section below*

☐ ARV Contraindicated Therapy***Include medical justification on Notes/Explanation section below*

Notes/Explanation: