ADAP – MEDCAP PRESCRIPTON FORM

ANTIRETROVIRAL (ARV) MEDICATIONS

Prescription fill x12. All ADAP prescriptions must be updated and resubmitted with Client Eligibility Reassessment (CER) twice a year.

ADAP/MEDCAP Prescription ADAP Revision _____ ADAP ID#_____

PATIENT NAME (Print): Last _____First _____MI_____ DOB: _____

	BRAND (Generic)	Dosage	Unit	Route	Frequency
	AGENERASE® (amprenavir or APV)				
	APTIVUS® (tipranavir or TPV)				
	ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate or EFV+FTC+TDF)				
	COMBIVIR® (lamivudine/zidovudine or 3TC+ZDV)				
	COMPLERA® (emtricitabine/rilpivirine/tenofovir disoproxil or FTC+RPV+TDF)				
	CRIXIVAN® (indinavir sulfate or IDV)				
	DESCOVY® (emtricitabine/tenofovir alafenamide or FTC+TAF or CBV)				
	EDURANT® (rilpivirine or RPV)				
	EMTRIVA® (emtricitabine or FTC)				
	EPIVIR® (lamivudine or 3TC)				
	EPZICOM® (abacavir sulfate/lamivudine or ABC+3TC)				
	EVOTAZ® (atazanavir sulfate/cobicistat or ATV+COBI)				
	FUZEON® (enfuvirtide or T-20 or ENF) *Requires prior authorization				
	GENVOYA® (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)				
	INTELENCE® (etravirine or ETR)				
	INVIRASE® (saquinavir mesylate or SQV)				
	ISENTRESS® (raltegravir or RAL)				
	KALETRA® (lopinavir/ritonavir or LPV+RTV)				
	LEXIVA® (fosamprenavir or FPV)				
	NORVIR® (ritonavir or RTV)				
	ODEFSEY® (emtricitabine/rilpivirine/tenofovir alafenamide or FTC+RPV+TAF)				
	PREZCOBIX® (darunavir/cobicistat or DRV+COBI)				
	PREZISTA® (darunavir or DRV)				
	RESCRIPTOR® (delavirdine mesylate or DLV)				
	RETROVIR® (zidovudine or AZT or ZDV)				
	REYATAZ® (atazanavir sulfate or ATV)				
	SELZENTRY® (maraviroc or MVC) *Requires prior authorization				
	STRIBILD® (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate)				
	SUSTIVA® (efavirenz or EFV)				
	TIVICAY® (dolutegravir or DOL or DTG)				
	TRIUMEQ® (dolutegravir/abacavir/lamivudine) *Requires prior authorization				
	TRIZIVIR® (abacavir/lamivudine/zidovudine or ABC+3TC+ZDV)				
	TRUVADA® (emtricitabine/tenofovir disoproxil fumarate or FTC+TDF)				
	VIDEX® or VIDEX® EC (didanosine or ddl) *circle VIDEX® or VIDEX® EC				
	VIRACEPT® (nelfinavir mesylate or NFV)				
	VIRAMUNE® or VIRAMUNE® ER (nevirapine) *circle VIRAMUNE® or VIRAMUNE® ER				
	VIREAD® (tenofovir disoproxil fumarate or TDF)				
	ZERIT® (stavudine or d4T)				
	ZIAGEN® (abacavir or ABC)				

___Check when requesting an ASAP Shipment ASAP Shipment Approved [ ] Denied [ ] Date _____ Initials_____

Prescriber (Print) _____ License#_____

Prescriber *(Signature)* _____ Date_____

Clinic Name/Address _____ City _____ State_____ Zip_____

ADAP – MEDCAP PRESCRIPTON FORM

OPPORUNTISTIC INFECTION (OI) MEDICATIONS

Prescription fill x12. All ADAP prescriptions must be updated and resubmitted with Client Eligibility Reassessment (CER) twice a year.

ADAP/MEDCAP Prescription ADAP Revision _____ ADAP ID#_____

PATIENT NAME (Print): Last _____First _____MI_____ DOB: _____

	BRAND (Generic)	Dosage	Unit	Route	Frequency
	ANCOBON® (flucytosine)				
	BACTRIM® DS (sulfamethixazole/trimethoprim or TMP/SMZ)				
	BIAXIN® (clarithromycin)				
	CLEOCIN® HCL (clindamycin hydrochloride, HCl)				
	DAPSONE (diaminodiphenyl sulfone or DDS)				
	DARAPRIM® (pyrimethamine) (not available at this time)				
	DELTASONE® (prednisone)				
	DIFLUCAN® (fluconazole)				
	FAMVIR® (famciclovir)				
	FOSCAVIR® (foscarnet)				
	FUNGIZONE® (amphotericin B)				
	ISONIAZID (isonicotinylhydrazide or INH)				
	MEGACE® (megestrol acetate)				
	MEPRON® (atovaquone)				
	MYAMBUTOL® (ethambutol hydrochloride, HCl)				
	MYCOBUTIN® (rifabutin)				
	NEBUPENT® (pentamidine isethionate)				
	PROBENECID (probenecid)				
	PROCRIT® (epoetin alfa) *Requires prior authorization				
	PYRAZINAMIDE (pyrazinamide or PZA)				
	SPORANOX® (itraconazole)				
	SULFADIAZINE (sulfadiazine, oral)				
	VALCYTE® (valganciclovir hydrochloride, HCl)				
	VALTREX® (valacyclovir)				
	VFEND® (voriconazole)				
	VISTIDE® (cidofovir)				
	WELLCOVORIN® (leucovorin)				
	ZITHROMAX® (azithromycin)				
	ZOVIRAX® (acyclovir)				

___Check when requesting an ASAP Shipment ASAP Shipment Approved [ ] Denied [ ] Date _____ Initials_____

Prescriber (Print) _____ **License#**_____

Prescriber *(Signature)* _____ **Date**_____

Clinic Name/Address _____ **City** _____ **State**_____ **Zip**_____

ADAP – MEDCAP PRESCRIPTON FORM

OTHER MEDICATIONS (VACCINES, HBV and/or HCV TREATMENTS)

Prescription fill x12. All ADAP prescriptions must be updated and resubmitted with Client Eligibility Reassessment (CER) twice a year.

ADAP/MEDCAP Prescription ADAP Revision _____ ADAP ID#_____

PATIENT NAME (Print): Last _____First _____MI_____ DOB: _____

	BRAND (Generic)	Dosage	Unit	Route	Frequency
	BARACLUD® (entecavir)				
	GARDASIL® (human papillomavirus (HPV) quad, types 6, 11, 16, & 18)				
	HAVRIX® (hepatitis A vaccine)				
	HEPSERA® (adefovir dipivoxil)				
	INTRON®A (interferon alfa-2b)				
	PEGASYS® (peginterferon alfa-2a)				
	PEGINTRON® (peginterferon alfa-2b)				
	PNEUMOVAX®23 (pneumococcal vaccine polyvalent)				
	REBETOL® (ribavirin)				
	REBETRON™ (interferon alfa-2b/ribavirin)				
	RECOMBIVAX HB® or ENGERIX-B (hepatitis B vaccine, recombinant)				
	ROFERON®-A (interferon alfa-2a, recombinant)				
	TWINRIX® (hepatitis A, inactive/hepatitis B, recombinant vaccine)				

___Check when requesting an ASAP Shipment ASAP Shipment Approved [ ] Denied [ ] Date _____ Initials_____

Prescriber (Print) _____ License#_____

Prescriber *(Signature)* _____ Date_____

Clinic Name/Address _____ City _____ State_____ Zip_____

ADAP – MEDCAP PRESCRIPTON FORM

ADAP/MEDCAP Prescription ADAP Revision _____ ADAP ID#_____

PATIENT NAME (Print): Last _____First _____MI_____ DOB: _____

	BRAND (Generic)	Dosage	Unit	Route	Frequency
	ALDERA™ (imiquimod, topical)				
	AMOXIL (amoxicillin)				
	AVELOX (moxifloxacin hydrochloride, HCl)				
	CELEXA® (citalopram hydrobromide)				
	COMBIVENT RESPIMAT® (ipratropium bromide/albuterol)				
	CRESTOR® (rosuvastatin calcium)				
	DIABETA (glyburide)				
	DOXYCYCLINE (doxycycline)				
	DYNACIN (minocycline)				
	ESKALITH CR (lithium carbonate)				
	GEODON (ziprasidone)				
	GLUCOPHAGE® (metformin hydrochloride, HCl)				
	GLUCOVANCE® (glyburide/metformin hydrochloride, HCl)				
	HYDROCHLOROTHIAZIDE (HCTZ) (hydrochlorothiazide or HCTZ)				
	KEFLEX® (cephalexin)				
	KEPPRA (levetiracetam)				
	LAMICTAL (lamotrigine)				
	LEXAPRO® (escitalopram oxalate)				
	LIPITOR® (atorvastatin calcium)				
	LOTENSIN (benazepril)				
	METRONIDAZOLE (metronidazole or MNZ)				
	NEURONTIN (gabapentin)				
	NIZORAL® (2% ketoconazole cream, topical)				
	NIZORAL® (ketoconazole tablets)				
	NIZORAL® AD (2% ketoconazole anti-dandruff shampoo)				
	NORVASC (amlodipine)				
	PAMELOR® (nortriptyline)				
	PAXIL® (paroxetine)				
	PHENERGAN (promethazine)				
	PRAVACHOL® (pravastatin)				
	PROVENTIL (albuterol)				
	PROZAC® (fluoxetine)				
	RISPERDAL® (risperidone)				
	TEGRETOL® (carbamazepine)				
	TRAZADONE (trazadone)				
	TRICOR (fenofibrate)				
	V-CILLIN K (penicillin v potassium)				
	WELLBUTRIN® (bupropion) *circle WELLBUTRIN® SR or WELLBUTRIN® XL				
	WELLBUTRIN® SR or WELLBUTRIN® XL (bupropion, sustained or extended release)				
	ZESTRIL (lisinopril)				
	ZOLOFT® (sertraline hydrochloride, HCl)				

___Check when requesting an ASAP Shipment ASAP Shipment Approved [ ] Denied [ ] Date _____ Initials_____

Prescriber (Print) _____ License#_____

Prescriber *(Signature)* _____ Date_____

Clinic Name/Address _____ City _____ State_____ Zip_____

ADAP – MEDCAP PRESCRIPTON FORM

Medications NOT on the Formulary (fill in this prescription section)

Prescription fill x12. All ADAP prescriptions must be updated and resubmitted with Client Eligibility Reassessment (CER) twice a year.

ADAP/MEDCAP Prescription ADAP Revision _____ ADAP ID#_____

PATIENT NAME (Print): Last _____First _____MI_____ DOB: _____

	BRAND (Generic)	Dosage	Unit	Route	Frequency

___Check when requesting an ASAP Shipment ASAP Shipment Approved [ ] Denied [ ] Date _____ Initials_____

***Medications requiring prior authorization will NOT be filled without additional documentation.**

****All MEDCAP Prescription requests can be sent directly to the Naphcare Pharmacy for filling.**

Prescriber Information

Prescriber (Print) _____License#_____

Prescriber *(Signature)* _____Date_____

Prescriber Phone # _____

Clinic Name _____

Clinic Shipping Address _____City _____State ____Zip Code_____

ELIGIBILITY OFFICE USE ONLY
Date to Central Pharmacy_____/_____/_____ ES Initials_____