

Arizona Ryan White and ADAP Application

MEDICAL PROVIDER PAGE-NEW APPLICANTS ONLY

MEDICAL PROVIDER SIGNATURE

I certify that to the best of my knowledge and believe all information I have provided below is accurate and complete.

Signature

Date

PROVIDER INFORMATION AND LAB DATA

Applicant Name	Applicant Birth Date		
Medical Provider Name	License Number		
Medical Provider Address	City	State	Zip Code
Medical Provider Phone ()	Medical Provider Fax ()		

TESTS

Test Name	Result	Date of Test
FUTURE LAB DRAW DATE		
CD4 CELL COUNT (medical provider can follow DHHS guidelines)		
VIRAL LOAD (within the last 6 months) - REQUIRED		

HEPATITIS C SCREENING

Does applicant have Hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would applicant like additional information about Hepatitis treatments through ADAP?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICATION(S) PRESCRIBED – ADAP ONLY

PLEASE list full prescription below, attach a current medication list, or attach a copy of the eRX

Drug	Strength	Quantity	Instructions	# Refills

I certify that this applicant has been diagnosed as having HIV infection.

I understand that I am required to notify the vendor pharmacy within 7 calendar days of the following:

- Prescribing a new medication
- Discontinuing a medication

I agree to notify the Arizona ADAP/Ryan White programs within 14 calendar days following my notification of:

- Death of patient/client
- Change in the HIV Medical Provider

If the client is going to go without Antiretroviral (ARV) Therapy for longer than 90 days or is on a ARV clinical trial, you will need to complete the 90 Day Medical Provider Override Form, for questions please contact ADAP directly.

Please return to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 280, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
Phone: Toll-Free (800) 334-1540