



ADAP Medical Exception Request Form

CLIENT NAME	DATE OF BIRTH	CLIENT Medical Record #	DATE

This form should be completed by a medical provider or designated clinical staff if the patient's condition cannot be safely managed for approximately 2-4 weeks while completing the patient assistance program process. If medications are needed immediately, please access Ryan White Part A, Part B, or other local resources.

PART I – EXCEPTION REQUESTS

- The client is post partum and in need of continued ARV therapy. *(Must provide details including date of delivery)*

- Other extreme medical condition - ***Please describe in detail your patient's current medical status (attach pertinent lab reports, resistance tests, and/or other documentation) that necessitates urgent enrollment prior to receipt of drug from Patient Assistance Programs (PAP's). Part A and/or Part B resources could be available for assistance in the interim between PAP application and receipt of drug.***

PART II – MEDICAL HISTORY

Is patient currently taking antiretroviral medications? Yes ___ No ___
 How many days of medication left? ____

CD4 HISTORY		
Date	CD4 Count	CD4%

VIRAL LOAD HISTORY		
Date	Viral Load	Viral Load Log

PART II – PROVIDER SIGNATURE

By signing below, I agree that the information provided in this form is accurate to the best of my knowledge.

 Print Clinician/Designee Name Clinician/Designee Signature Date

 Clinician Contact Number CHD Clinic /Office Name Clinic Secure Fax #

PART IV – MEDICAL TEAM APPROVAL

 Medical Team Staff Name Medical Team Staff Signature Date

- Approved Not Approved