GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration

DC AIDS Drug Assistance Program
Request for Early Refill and/or Extended Supply of Medication

To be completed by the ADAP client's physician and case manager (if applicable).
Fax completed form(s) to the DC ADAP office at (202) 673-4365.
Requests are processed within three business days.

PHYSICIAN

I request that the DC AIDS Drug Assistance Program (DC ADAP) authorize an early refill and/or extended supply of medication for my patient,

(*name and date of birth*) _____, due to the following circumstances (check all that apply):

☐ Travel outside of the District
☐ Other: (*provide details*) _____

_____.

My patient needs a (*number of days*) _____ supply of medication[1] and he/she needs to pick up the medication on (*approximate pick-up date*) _____.

My patient's current HIV drug regimen (strength & dosage of medication) is:_____

_____

By signing this form I attest to the fact that the patient indicated above is in good standing and receives regular medical care from me, and has a medical appointment scheduled with me after returning to the District (if travel supply requested).

Physician name:_____ Physician signature:_____

National Provider Identifier (NPI)[2]:_____ Phone number:_____

Date:_____

NOTE: A MAXIMUM OF ONE 90-DAY SUPPLY WILL BE AUTHORIZED PER YEAR.
PLEASE FAX COMPLETED FORM BACK TO (202) 673-4365.

[1] Early refill/extended supply requests for controlled substances will not be granted.
[2] Prescribing physician must have a District of Columbia, Maryland, or Virginia NPI and license number.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration

CASE MANAGER (*if applicable*)

I am requesting that the DC AIDS Drug Assistance Program (DC ADAP) authorize an early refill and/or extended supply of medication for my client,

(*name and date of birth*) _____, due to the following circumstances (check all that apply):

☐ Travel outside of the District
☐ Other: (*provide details*) _____

_____

My patient needs a (*number of days*) _____ supply of medication and he/she needs to pick up the medication on (*approximate pick-up date*) _____.

My client's pharmacy from which medication is to be picked up:_____

My client's current HIV drug regimen ((strength & dosage of medication) is:_____

_____

By signing this form I attest to the fact that the client indicated above is in regular medical care, he or she has a medical appointment scheduled with his or her doctor after returning to the District (if travel supply requested).

Case manager name:_____

Case manager signature:_____

Case manager agency:_____

Phone number:_____

Date:_____

NOTE: A MAXIMUM OF ONE 90-DAY SUPPLY WILL BE AUTHORIZED PER YEAR.

PLEASE FAX COMPLETED FORM BACK TO (202) 673-4365.