SC ADAP DIRECT DISPENSING APPLICATION

D H E C
PROMOTE PROTECT PROSPER

Return to:
Direct Dispensing Program (DDP)
3rd Floor, Mills Jarrett
Box 101106, Columbia, SC 29211
PH: (803) 898-0174 or (800) 856-9954
FAX: (803) 898-0475

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received: _____ Status/Date: _____
Final Status/Date: _____
Completed By: _____

Instructions: This form is for applicants applying to the SC ADAP Direct Dispensing Program.

I. APPLICANT INFORMATION **ADAP ID:**

Last Name: _____ First Name: _____ Full Middle Name: _____

Date of Birth: ____/____/____ Social Security #: ____-____-____ Gender: _____

If no Social Security #, has applicant lived in SC for at least 3 months? o Yes o No

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip code: _____ County: _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone (_____) _____ Other Phone (_____) _____

Ethnicity (check one): o Hispanic/Latino (a) o Non-Hispanic/Latino (a)

Race (check all that apply): o Asian o American Indian or Alaskan Native o Black o White
o Native Hawaiian or Other Pacific Islander o Unknown o Other_____

II. ELIGIBILITY INFORMATION *(Please attach a separate page for income if more pages are needed for additional household members)*

Applicant and Other Members in Household	Relationship to Applicant	Gender	Date of Birth	Place of Employment or Source of Other Income	Estimated **Yearly Gross** Income
Applicant					

Acceptable documentation: most current pay stubs, most current W2 forms, most current Federal Tax Return, Pensions, Unemployment Compensation, Social Security Benefits, Alimony, Child Support, Workers Compensation, Wage Statement, or Employer letter (on company letterhead, dated and signed with salary information).

III. CERTIFICATION/CONSENT

1. I certify that the information provided in this application is true and correct to the best of my knowledge.
2. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program.
3. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship.
4. I also understand the importance of taking medications as prescribed and that failure to do so may result in my being dropped from the program after 60 days. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.
5. I give permission to ADAP to verify this information, either through written documentation or electronic files.
6. By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager indicated on the next page.
7. By my signature below as parent, guardian or applicant, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me.
8. Permission is also granted to DHEC to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services.

_____ _____
Applicant's Signature Date

APPLICANT NAME: _____ **DOB:** _____

IV. BENEFITS INFORMATION (To be completed by the Case Manager, Nurse, or Physician)

Does the applicant have medical insurance with prescription coverage? o Yes* o No
*If yes, attach copy of front and back of insurance card

Does the applicant have Medicaid coverage? o Yes o No Medicaid application pending? o Yes o No

Does the applicant have Medicare Part D coverage? o Yes o No Medicare Part D application pending? o Yes o No

V. CLINICAL INFORMATION (To be completed by the Physician)

Is the applicant HIV+ o Yes o No Date of diagnosis: _____/_____/_____or o Unknown

The ***most recent*** CD4 (T4) lymphocyte count was _____on _____/_____/_____(date drawn)

The ***most recent*** viral load result was _____on _____/_____/_____(date drawn) o Pretreatment? o On therapy?

The applicant's current clinical status is: o Asymptomatic o Symptomatic Meets the CDC's case definition of AIDS? o Yes o No

Check the medications prescribed (applications will be returned as incomplete if no medications are checked)

- o Abacavir (Ziagen)
- o Abacavir, Lamivudine, (Epzicom)
- o Abacavir, Lamivudine, Zidovudine (Trizivir)
- o Acyclovir (Zovirax)
- o Amitriptyline (Elavil)
- o Amoxicillan
- o Amoxicillin, Clavulanate (Augmentin)
- o Atazanavir (Reyataz)
- o Atovaquone (Mepron)
- o Azithromycin (Zithromax)
- o Bupropion (Wellbutrin)
- o Ciprofloxacin (Cipro)
- o Citalopram (Celexa)
- o Clarithromycin (Biaxin)
- o Clindamycin (Cleocin)
- o Clotrimazole (Mycelex)
- o Clotrimazole/Betamethasone
- o Dapsone
- o Darunavir (Prezista)
- o Delavirdine (Rescriptor)
- o Didanosine (ddI, Videx)
- o Doxycycline (Vibramycin)
- o Duloxetine (Cymbalta)
- o Efavirenz (Sustiva)
- o Efavirenz, Emtricitabine, Tenofovir (Atripla)
- o Elvitegravir, Cobicistat, Emtricitabine, Tenofovir Disoproxil Fumarate (Stribild)
- o Emtricitabine (Emtriva)
- o Emtricitabine, Tenofovir (Truvada)
- o Enfuvirtide (Fuzeon)*
- o Escitalopram (Lexapro)
- o Ethambutol (Myambutol)
- o Etravirine (Intelence)
- o Famciclovir (Famvir)
- o Fluconazole (Diflucan)
- o Fluoxetine (Prozac)
- o Fosamprenavir (Lexiva)
- o Gabapentin (Neurontin)
- o Indinavir (Crixivan)
- o Itraconazole (Sporanox)
- o Ketoconazole (Nizoral)
- o Lamivudine (3TC, Epivir)
- o Lamivudine, Zidovudine (Combivir)
- o Leucovorin
- o Levofloxacin (Levaquin)
- o Lopinavir, Ritonavir (Kaletra)
- o Maraviroc (Selzentry)*
- o Metronidazole (Flagyl)
- o Mirtazapine (Remeron)
- o Moxifloxacin (Avelox)
- o Nelfinavir (Viracept)
- o Nevirapine (Viramune)
- o Nystatin (Mycostatin)
- o Nystatin/Triamcinolone
- o Oseltamivir (Tamiflu)
- o Paroxetine (Paxil)
- o Peginterferon (Pegasys) *
- o Peginterferon (PEG-Intron)*
- o Pravastatin (Pravachol)
- o Prednisone
- o Promethazine
- o Pyrimethamine (Daraprim)
- o Raltegravir (Isentress)
- o Ribavirin (Copegus, Rebetol)
- o Rifabutin (Mycobutin)
- o Rilpivirine (Edurant)
- o Rilpivirine, Emtricitabine, Tenofovir (Complera)
- o Ritonavir (Norvir)
- o Rosuvastatin (Crestor)
- o Saquinavir (Invirase)
- o Sertraline (Zoloft)
- o Simvastatin (Zocor)
- o Stavudine (d4T, Zerit)
- o Sulfadiazine
- o Sulfamethoxazole/TMP (Bactrim DS, Septra DS)
- o Tenofovir (Viread)
- o Tipranavir (Aptivus)
- o Trazodone (Desyrl)
- o Valacyclovir (Valtrex)
- o Valganciclovir (Valcyte)
- o Venlafaxine (Effexor)
- o Voriconazole (Vfend)
- o Zanamivir (Relenza)
- o Zidovudine (AZT, ZDV, Retrovir)

Requires prior authorization for first ADAP prescription – attach Prior Authorization form to application.

Referring Physician (Print Name)	Signature	Date	Organization (Please Print)	Phone

Address	City	State	Zip Code	State Medical License#	DEA#

Referring Case Manager (Print Name)	Signature	Date	Organization (Please Print)	Phone

Case Manager if NOT the Referring Case Manager (Print Name)	Signature	Date	Organization (Please Print)	Phone

SC ADAP DIRECT DISPENSING PROGRAM (DDP)
APPLICATION Instructions - DHEC 1534

Purpose: This form will be used to provide relevant information to determine the applicant's eligibility for the SC ADAP Direct Dispensing Program (DDP).

Important:
This form must be completed and signed by the applicant AND the applicant's physician or case manager. All of the supporting documentation (including income documentation) must be submitted with the form.

Instructions:
I. Applicant Information
ADAP ID: Enter the applicant's ADAP ID, if available
Name: Enter the applicant's last, first, and full middle name.
Date of Birth: Enter the month, day, and year of the applicant's birth.
Social Security Number: Enter the applicant's social security number. Contact the SC ADAP staff if the applicant does not have a social security number.
Gender: Enter the applicant's gender (Male, Female, or Transgender).
If no Social Security # is provided, indicate if the applicant has lived in SC for at least 3 months.
Home Address: Enter the street address where the applicant lives. Do not enter a PO Box.
County: Enter the county name where the applicant lives.
Mailing Address: If different from the street address, enter the address (Street or PO Box #) where the applicant wants to receive medications and other correspondence. *NOTE:* You must notify SC ADAP immediately if there is a change in the mailing address.
Telephone: Enter the area code and telephone number where the applicant can be reached. Please list both home and work numbers, if possible. *NOTE:* You must notify SC ADAP immediately if there is a change in the telephone number.
Ethnicity: Enter the applicant's ethnicity.
Race: Enter the applicant's race.

II. Eligibility Information
Financial Data: List the following in the table:
Place of employment, estimated yearly income of the applicant.
Other members of the household, relationship to the applicant, gender, date of birth, place of employment or source of income. Write "unemployed" if not working - do not write N/A, do not leave blank and do not draw a line through the space.
Proof of income is required for the applicant and for each member of the household listed in the application.
NOTE: The Eligibility Information section is important and must be completed or the form will be returned. Please enter all of the information including a complete list of the household dependents and their individual income documentation (this may be useful in determining if the applicant qualifies for the program).

III. Certification and Consent
Consent: This section is mandatory. The applicant must read and understand the conditions for acceptance into the program and sign on the line *"Applicant's Signature"* and date the application.

IV. Benefits Information
Private Medical Insurance: Check the appropriate box if the applicant has private insurance (through employer, or self).
Medicaid coverage: Check the appropriate box if the applicant has Medicaid coverage.
Medicaid application pending: Check the appropriate box if the applicant's Medicaid application is pending.
Medicare Part D coverage: Check the appropriate box if the applicant has Medicare Part D coverage.

Medicare Part D application pending: Check the appropriate box if the applicant has an application pending for Med D coverage.

V. Clinical Information *(This section should be completed by the physician)*

HIV status: Check the appropriate box for HIV status. Enter date of diagnosis.

CD4 count: Enter the most recent CD4 count and the date the blood was drawn.

Viral load: Enter the most recent Viral Load information and the date the blood was drawn.

Clinical status: Check the appropriate box for the current Clinical Status (Asymptomatic/Symptomatic) and if the applicant meets the CDC's definition for AIDS.

Medications: Check the appropriate box(es) for all the drugs being prescribed to the applicant. Note that SC ADAP will not enroll an applicant unless he/she is on medications.

Signatures: All applications MUST be signed by the physician and case manager and/or referring case manager. See below for definitions:

Referring physician's signature: The referring physician must sign and date this section. The organization name must be printed clearly.

Referring case manager: The referring case manager, if applicable, must sign and date this section. The organization name must be printed clearly. The referring case manager is typically the applicant's nurse or social worker who actively monitors the applicant's clinical progress and treatment adherence.

Case manager if not the referring case manager: This section is to be completed if the applicant has a case manager who's different from the referring case manager. The case manager should sign and date this section. The organization name must be printed clearly. This case manager is usually a nurse or social worker who assists the applicant with completing the application. In some instances, the application will be forwarded to another nurse or social worker who actively monitors the applicant's clinical progress and treatment adherence.

Office Mechanics

Protected Health Information: This form contains Protected Health Information (PHI) and should be stored and/or disposed in accordance with your organization's privacy policy. Appropriate forms of storage include but are not limited to: 1) in imaged format and secured in your electronic health record (EHR) system, 2) in paper format in each patient's secure chart/file, 3) shredded in accordance with your organization's privacy policy. This record of disclosure must remain available for a six (6) year retention period.

Completed applications must be submitted into Provide Enterprise by the enrollee's Case Manager or mailed / faxed to:

SC ADAP Direct Dispensing Program
3rd Floor, Mills Jarrett
Box 101106
Columbia, SC 29211

FAX: (803) 898-0475