

ADAP Program

Rx FAX

TO: **Welvista** FROM: _____
PHONE: 1-877-258-1556 PHONE: _____
FAX: 1-877-258-1557 FAX: _____
PAGES: _____
DATE: _____

Medications covered under the ADAP Program

Norvir **ISENTRESS**
KALETRA **CRIVAN**

Patient Last Name (Print) _____ Patient First Name (Print) _____
Patient DOB _____ Patient Phone # _____
Ship to Address (Print) _____
Ship to Address (Print) _____
City _____ State _____ Zip _____
Ship to Contact Name (Print) _____ Contact Phone # _____

I attest that the patient below is currently on a State ADAP wait list and meets the state of residency's ADAP program requirements. I agree that if there is a change in the patient status with the ADAP program I will notify Welvista immediately. This patient under the State ADAP program is ___uninsured or ___underinsured (please check appropriate box).

Authorized Signature **Date**

NAME _____

ADDRESS _____ DATE _____

Rx

REFILLS _____

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

DEA# _____
LICENSE# _____
NPI# _____

Prescriber Name (Print) _____
Prescriber Phone# _____