

ILLINOIS AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Atovaquone (Mepron) Drug Authorization Request Form
Required For Prescriptions > 21 Days

Fax Completed Form To: 217-785-8013
Questions or Inquires May Be directed To: 1-800-825-3518

Provide All Information Requested Below

Note: Additional documentation may be required in some situations.

Patient information: First Name: Last Name: Date of Birth:	Physician information: First Name: Last Name: Telephone Number: Fax Number:
Last CD4 count: _____ Date of collection for last CD4 count: _____	Contact person for request: First Name: Last Name: Telephone Number: Fax Number:

1. Expected duration of therapy with atovaquone: _____ months.

2. Reason for requesting greater than 21 day supply of atovaquone:

A. PCP Prophylaxis

- Patient cannot tolerate TMP-SMX. Explain: _____
- Patient cannot tolerate dapsone. Explain: _____
- Nebulized pentamidine cannot be used for PCP prophylaxis. Explain: _____
- Other: _____

B. Toxoplasmosis

- Atovaquone is needed for toxoplasmosis treatment.
Explain _____
 - Atovaquone is needed for toxoplasmosis prophylaxis. Explain _____
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