Illinois Department of Public Health

AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) is making available to a limited number of ADAP clients, the FDA approved drug Valcyte™ (valganciclovir hydrochloride), manufactured by Roche Laboratories. A limit of 35 clients will be approved for Valcyte™ (valganciclovir hydrochloride) assistance through ADAP. Clients will be required to meet the medical criteria defined below. Physicians will be notified if applicant is approved and instructed where to send or fax the prescription.

Application for Valcyte™ (valganciclovir hydrochloride) Assistance

To be eligible for Valcyte™ (valganciclovir hydrochloride) Assistance a client must:

- Be currently enrolled in ADAP and eligible to receive services.
- Not be eligible for payment of Valcyte™ (valganciclovir hydrochloride) through Medicaid or other third party payer.
- Have experienced failure of the current HAART regimen.
- Have a CD4 count less than 500
- Have viral load greater than 1,000

Applicant's

Social Security Number _____ **Date of Birth** _____

First Name _____ **Middle** _____ **Last Name**_____

Address _____

City _____ **State** _____ **Zip** _____

Please complete the above information and provide test results and documentation of the following:

1. Most recent viral load (within the past 3 months) >1000.
2. Most recent CD4 count <500 (within the past 3 months), or history of opportunistic infection; use during pregnancy may be based on expert advice.
3. Resistance testing (performed within the past 3 months) and based on the test results, medically appropriate 3 drug regimen cannot be constructed utilizing drugs other than Valcyte™ (valganciclovir hydrochloride).
4. Suitable arrangements for administration of Valcyte™ (valganciclovir hydrochloride) have been made. Please specify who will administer the Valcyte™ (valganciclovir hydrochloride).
5. Please specify who will assume responsibility for Valcyte™ (valganciclovir hydrochloride) upon shipment arrival.
6. Address where drug will be sent if approved:_____

Physicians Name: (Print)_____Signature:_____

Phone Number: _____ Fax Number: _____

Authorization Date:	Authorization Number:

Clinic affiliation where this patient/client is seen:_____

Submit to: Illinois Department of Public Health
ADAP
525 West Jefferson Street, 1st Flr.
Springfield, IL 62761

or Fax to: 217/785-8013