

## Illinois Department of Public Health

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.

### ADAP Application for oral Valcyte™ (valganciclovir hydrochloride) Assistance

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

- Be currently enrolled in ADAP and eligible to receive services.
- Not be eligible for payment for valganciclovir through Medicaid or other third party payer; and
- Be prescribed oral valganciclovir for induction or maintenance treatment of cytomegalovirus (CMV) retinitis that has been diagnosed by an ophthalmologist, and be under the care of an ophthalmologist, or
- Have a condition other than retinitis that is documented to be due to CMV for which use of oral valganciclovir is approved by the ADAP program based on review of medical records.

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### Applicant Information:

Name: \_\_\_\_\_  
                    **First**  **MI**  **Last**

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
                    **City**  **State**  **Zip** \_\_\_\_\_

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

1. Documentation of diagnosis of CMV infection ( by an ophthalmologist for CMV retinitis)
2. Most recent CD4 counts ( from past 6 months); Patients with a sustained (6 month) increase in CD4+ counts >100 cells/ $\mu$ L in response to antiretroviral therapy require consultative note from an ophthalmologist indicating that valganciclovir therapy continues to be recommended.

Physicians Name: (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Clinic affiliation where this patient/client is seen: \_\_\_\_\_

**Submit to:** Illinois Department of Public Health      **or**      Fax to: 217/785-8013  
                    ADAP  
                    525 West Jefferson Street, 1<sup>st</sup> Flr.  
                    Springfield, IL 62761

### FOR ADAP OFFICE USE ONLY:

**Authorization Date:**

**Authorization Number:**