State of Illinois
Illinois Department of Public Health

Ryan White Part B ADAP Medication Assistance Program (MAP)

Application for Pre Approval of oral Valcyte™ (valganciclovir hydrochloride) Assistance

(click on the name to take you directly to the specific Prescribing Guidelines)

To be eligible for Assistance for oral Valcyte™ (valganciclovir hydrochloride), a client must meet all of the following:

1. Be currently enrolled in ADAP/MAP and eligible to receive services.
2. Have been denied medication coverage by their insurance plan (if applicable) - **(documentation required)**
3. Meet one of the following:
a. Be prescribed oral Valcyte™ for induction or maintenance treatment of cytomegalovirus (CMV) retinitis that has been diagnosed by an ophthalmologist, and be under the care of an ophthalmologist. **(documentation required)**
OR
b. 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/MAP program based on review of medical records.

Complete the following:

Applicant's Name _____
Legal First Middle Last

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

Address _____

City _____ **State** _____ **ZIP Code** _____

Most recent CD4 count: _____ - results must be dated within the past 6 months - **(documentation required)**

- Patients with a sustained (6 month) increase in CD4+ counts >100 cells/µL in response to antiretroviral therapy **ALSO** require consultative note from an ophthalmologist indicating that Valcyte™ (valganciclovir hydrochloride) therapy continues to be recommended.

Has client been diagnosed with CMV Retinitis? Y / N **(documentation required for "Yes" answer)**

Name of Ophthalmologist diagnosing CMV Retinitis? _____

*****NOTE: A limit of 35 clients can be approved for Valcyte™ (valganciclovir hydrochloride) assistance at a given time. Physicians will be notified if applicant is approved and instructed where to send or fax the prescription.***

Physician Name: (Print) _____ **Clinic:** _____

Phone Number: _____ **Fax Number:** _____

Provider Signature: _____

Provider must acknowledge the following with initials:

_____ I have reviewed the Prescribing guidelines for possible interactions and issues of the medication regimen I am prescribing.

_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen

Submit to: Illinois Department of Public Health **or** Fax to: 217-785-8013
525 W. Jefferson St., 1st Floor, Springfield, IL 62761

IDPH USE ONLY: Authorization Approved? ❑ YES ❑ NO Authorization Number: _____

Authorization Effective Date: _____ Authorization Expiration Date: _____