GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration

DC AIDS Drug Assistance Program
Request for Early Refill and/or Extended Supply of Medication

To be completed by the ADAP client's physician and case manager (if applicable).
Requests are processed within three business days.

PLEASE NOTE: A MAXIUM OF ONE 90-DAY SUPPLY WILL BE AUTHORIZED PER YEAR

PHYSICIAN

Patient's Name: ____**Date of Birth**: __________________

Pharmacy Benefits ID Number: ____

Reason for early and/or extended refill:
- ☐ Travel outside of the District:
- ☐ Other (provide details): ____

____

Day Supply Requested: ___________ **Date the patient will be picking up medication(s):** ________________

Patient's Pharmacy: ____

Please list the name, strength, dosage, and NDC of medication(s) needed[1]:

1. ____NDC:_________________________
2. ____NDC:_________________________
3. ____NDC:_________________________
4. ____NDC:_________________________
5. ____NDC:_________________________
6. ____NDC:_________________________

By signing this form I attest that the patient indicated above is in good standing and receives regular medical care from me, and has a medical appointment scheduled with me after returning to the district (if travel supply is requested).

Physician Name (Print):________________________________ Physician Signature_____________________________

National Provider Identifier (NPI) [2]:________________________Phone Number: ________________________________

Date: _____________

PLEASE FAX COMPLETED FORM to the DC ADAP OFFICE at (202)-673-4365

[1] Early refill/extended supply requests for controlled substances will not be granted.
[2] Prescribing physicians must have a District of Columbia, Maryland, or Virginia NPI license number.

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PLEASE NOTE: A MAXIUM OF ONE 90-DAY SUPPLY WILL BE AUTHORIZED PER YEAR

Case Manager *(if applicable)*

Patient's Name: ____ **Date of Birth**: ________________

Pharmacy Benefits ID Number: __________________________________

Reason for early and/or extended refill:
- ☐ Travel outside of the District:
- ☐ Other (provide details): ____

____

Day Supply Requested: __________ **Date the patient will be picking up medication(s):** ______________

Patient's Pharmacy: ____

Please list the name, strength, dosage, and NDC of medication(s) needed[1]:

1. ____ NDC: __________________________
2. ____ NDC: __________________________
3. ____ NDC: __________________________
4. ____ NDC: __________________________
5. ____ NDC: __________________________
6. ____ NDC: __________________________

By signing this form I attest that the patient indicated above is in good standing and receives regular medical care from me, and has a medical appointment scheduled with his or her doctor after returning to the district (if travel supply is requested).

Case Manager Name (Print): ____________________________ Case Manager Signature: ___________________

Case Manager Agency: _____________________________ Phone Number: ___________________________

Date: ____________

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[1] Early refill/extended supply requests for controlled substances will not be granted.