

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 MAXIMUM 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) needed¹:

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.