

Welvista ADAP Enrollment Form

Rx FAX

TO: **Welvista** FROM: _____
PHONE: 1-877-258-1556 PHONE: _____
FAX: 1-877-258-1557 FAX: _____
PAGES: _____
DATE: _____

Medications covered under the ADAP Program

Norvir Isentress Prezista Atripla Truvada Epzicom Ziagen Selzentry Combivir Epivir Reyataz Aptivus Viamune
Kaletra Crixivan Intelence Viread Emtriva Trizivir Viracept Retrovir Rescriptor Lexiva Sustiva ViamuneXR Edurant

Patient Last Name (Print) _____ Patient First Name (Print) _____
Patient DOB _____ Patient Phone # _____
Ship to Address (Print) _____
City _____ State _____ Zip _____
Ship to Contact Name (Print) _____ Contact Phone # _____

I attest that the patient below is currently on a State ADAP wait list and meets the state of residency's ADAP program requirements. I agree that if there is a change in the patient status with the ADAP program I will notify Welvista immediately. This patient under the State ADAP program is ___uninsured or ___underinsured (please check appropriate box).

Print Name Authorized Signature Date

NAME _____	
ADDRESS _____	DATE _____
Rx	
REFILLS _____	
DISPENSE AS WRITTEN _____	SUBSTITUTION PERMITTED _____
DEA# _____	Prescriber Name (Print) _____
LICENSE# _____	Prescriber Phone# _____
NPI# _____	Prescriber Address: _____

Note: All documentation to include Welvista ADAP Enrollment Form, prescription (if separate), and state wait list notification letter must be received before prescriptions are processed.