

Ryan White Part B ADAP Medication Assistance Program (MAP)

Application for Pre Approval of MEPRON® (atovaquone) prescription exceeding 21 days (click on the name to take you directly to the specific Prescribing Guidelines)

Τo	be eligible for a	Mepron	prescription to	exceed 21 d	lays, 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)

Complete the following:								
Applicant's Name Legal First	Middle	Last						
Social Security Numberaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa								
Address aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa								
City	State	ZIP Code						
Duration of Mepron Prescription requested: (indicate days/weeks/months)								
Reason for request of Mepron (Select all that apply)								
A. PCP Prophylaxis								
Patient Cannot Tolerate TMP-SMX. Explain:								
Patient Cannot Tolerate dapsone. Explain:								
Nebulized pentamidine cannot be used for PCP prophylaxis. Explain:								
Other:								
B. Toxoplasmosis								
Mepron is needed for toxoplasmosis treatment. Explain:								
Mepron is needed for toxoplasmosis prophylaxis. Explai	n:							
Other:								
District Name (D.1.0)	Cl							
Physician Name: (Print)	Clinic:							
Phone Number:								
Provider Signature:								
Duaridan must calmandada the following with initials.								
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								
Patient has been counseled on the high cost of tr		0% adherent to treatment regimen						
Patient has been counseled on the high cost of tr		0% adherent to treatment regimen						
Submit to: Illinois Department of Public Health	or Fax to: 21	0% adherent to treatment regimen 7-785-8013						
	or Fax to: 21	•						
Submit to: Illinois Department of Public Health 525 W. Jefferson St., 1st Floor, Springfield, IL 627	or Fax to: 21	7-785-8013						
Submit to: Illinois Department of Public Health	or Fax to: 21	7-785-8013						