ARIZONA AIDS DRUG ASSISTANCE PROGRAM (ADAP)

EGRIFTA SV APPLICATION

Please complete all of the following Patient/Physician information:

Patient Name: (Please Print)_____**Patient Phone:** (__)_____

Patient Address:_____

List Patient Allergy (if any):_____

Patient Date of Birth:_____

MD Name:_____ **MD Specialty:**_____

MD Phone#: (__)_____ **MD Fax:** ( )_____

MD DEA #:_____ **MD NPI#:**_____

QUESTIONS/INDICATIONS FOR MEDICAL NECESSITY:

Medication	***Strength:***	***Directions:***
☐ **Egrifta SV**	**2mg**	Inject subcutaneously every day, as directed

Does this patient have a diagnosis of:

☐ HIV related lypodystrophy ☐ Other diagnosis (Please List):_____

1. **Is the Patient between 18 and 65 years old?** ☐ Yes ☐ No
2. Is the patient currently receiving antiretroviral therapy? ☐ Yes ☐ No
   If so, please list:_____
3. **Please provide initial waist circumference:**_____
   Must be greater than 95 cm (37.4 inches) for males and 94 cm (37 inches) for females
   For continued therapy, please provide current waist circumference:_____ Date measured:_____
4. **Please provide waist to hip ratio:** _____
   Must be greater than 0.94 for males and greater than 0.88 for females
5. **Please provide Fasting Blood Glucose:** _____mg/dL
   Must be less than 150mg/dL
6. **Does this patient have?**
   ☐ BMI less than or equal to 20kg/m2 ☐ Active Malignancy
   ☐ Hypopituitarism ☐ Currently Pregnant
7. **Please list all other treatment regimens, including diet and exercise, that have failed for this patient in treating lypodystrophy**:_____
   _____
8. **Any additional information may be provided here:**_____
   _____

Physician Signature: _____ **Date** _____

Please submit this form and any supporting documentations to the ADAP office by mail or fax (602-364-3263). If you have any questions, please call (602) 364-3610 (in State) or (800) 334-1540 (toll free).