

**ARIZONA AIDS DRUG ASSISTANCE PROGRAM (ADAP)  
VALGANCICLOVIR APPLICATION**

Client Name \_\_\_\_\_ Date of Application \_\_\_\_\_

**General Indications**

Are you going to be using valganciclovir as a primary prophylaxis for this client?

Yes       No

Are you going to be using valganciclovir for secondary prevention of CMV infection?

Yes       No

How was CMV disease documented? \_\_\_\_\_

\*Most recent serum creatinine \_\_\_\_\_ Date obtained \_\_\_\_\_

Calculated creatinine clearance \_\_\_\_\_

\*Most recent viral load \_\_\_\_\_ Date obtained \_\_\_\_\_

\*Most recent CD4 count \_\_\_\_\_ Date obtained \_\_\_\_\_

\*Most recent white blood count \_\_\_\_\_ Date obtained \_\_\_\_\_

\*Most recent hemoglobin/hematocrit count \_\_\_\_\_ Date obtained \_\_\_\_\_

\*Most recent platelet count \_\_\_\_\_ Date obtained \_\_\_\_\_

**\*Please attach or fax most recent serum creatinine, viral load, CD4 count, white blood count, hemoglobin/hematocrit count and platelet count lab reports.**

Patient will have repeat HIV RNA and CD4 counts performed 12 and 24 weeks after initiation of valganciclovir to assess the duration of therapy.

If this patient does not meet current ADAP guidelines for valganciclovir use, please provide information regarding the medical necessity and justification for use. \_\_\_\_\_

Physician Signature\*\* \_\_\_\_\_

\*\*If submitting electronically, typing your name will serve as an electronic signature.

**Please submit this form to the ADAP office by e-mail (hadzihmu@azdhs.gov) or fax (602-364-3263). If submitting electronically, please save the file as a unique, identifiable file name. Copies of lab reports may be faxed if electronic copies are not available. HIPAA regulations must be followed when transmitting documents with patient-identifying information. If you have any questions, please call 602-364-3594.**