

NC AIDS Drug Assistance Program (ADAP) - Application for Patient Access to Selzentry

Patient Name: _____

Address: _____

City: _____ ZIP Code: _____ Soc. Sec. #: XXX-XX-_____
(last 4 digits only)

County: _____ DOB: _____

Clinician's Name: _____ Phone #: (____) _____

Practice Name: _____ Fax #: (____) _____

Office Address: _____ E-mail: _____@_____

City : _____ ZIP Code: _____ County: _____

Name of Contact at Office (if not clinician): _____

➤ **Selzentry**

YES NO *

Has tropism testing been done and the results included with this application?
The Trofile Test by Monogram is the only tropism test accepted by the ADAP Program

**Please attach a written explanation for any response of "No".*

Clinician Signature: _____ Date: _____

Complete this application in its entirety. Sign, date, and forward to:

Authorization Unit Office of Purchase of Medical Care Services 1904 Mail Service Center Raleigh, NC 27699-1904	Authorization Unit Phone (919) 855-3701 Forms may also be faxed to (919) 715-5221
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For POMCS Use only: ADAP Number _____
Medicaid: Yes No