Maryland AIDS Drug Assistance Program
500 N. Calvert St., 5th Fl., Baltimore, MD 21202
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308
or TTY- Maryland Relay Service 1-800-735-2258
Fax Numbers: (410) 333-2608; (410) 244-8617
Website:http://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx

A-1: MADAP Medical Eligibility Form

Instructions: This form must be completed by the licensed medical practitioner who provides the applicant's HIV-related care. Once all sections have been completed, signed and dated, it may be submitted to MADAP with the rest of the application or faxed to MADAP by the provider.

Applicant's Information:

First Name: _____ **MI:** ____ **Last Name**: _____ **Suffix:** ____

Date of Birth: ____/____/____ **Social Security Number:** ___-____-____

☐ *Check here if you do not have a social security number.*

1. Viral Status:

Is this patient HIV infected? ☐ **Yes** ☐ **No** *(If **No**, stop here, this patient is ineligible for MADAP)*	
Has this patient's case been reported by you to the local health department as required by state law? ☐ **Yes** ☐ **No**	
Does this patient have a CD4+ T-lymphocyte test result that was <200 cells/µL (14%)? *If this patient is <1 yr. of age, evidence of CD4+ test result <750 cells/µL (<26%)?* *If this patient is 1-5 yrs. of age, evidence of CD4+ test result <500 cells/µL (<22%)?*	☐ **Yes** **Date** __/__/___ ☐ **No** ☐ **Unknown**
Has this patient been diagnosed with any Stage-3-defining opportunistic illness by CDC case definition* for HIV Infection?	☐ **Yes** **Date** __/__/___ ☐ **No** ☐ **Unknown**
Does this patient have a history of Hepatitis C virus (HCV) infection?	☐ **Yes, with detectable HCV RNA** ☐ **No, HCV ab negative/undetectable HCV RNA** ☐ **Yes, with undetectable HCV RNA from treatment** ☐ **Has no record of HCV testing**

**Revised Surveillance Case Definition for HIV Infection – United States, 2014: MMWR 2014;63(No RR-03):1-10* Website: www.cdc.gov/mmwr

2. Medication: *Applicant must be on HIV antiretroviral medications or have ARVs prescribed within 3 months of submitting this application to be eligible for MADAP.*

Are you currently prescribing at least one of the HIV antiretroviral medications on the Maryland AIDS Drug Assistance Program (MADAP) formulary?	☐ **Yes** ☐ **No**
If No, are you planning to prescribe at least one of the HIV antiretroviral medications on the MADAP formulary in the next 3 months?	☐ **Yes** ☐ **No**

3. Laboratory Reports:

Enter this patient's most recent CD4 Count and Viral Load test results.

If the patient's CD4 count is >500 cells/µL and Viral Load is < 200 copies/mL, the CD4 test date may be older than 12 months.

VIRAL LOAD test date must be within the last 12 months.

	Test Date	Test Result
CD4 Count	mm dd yyyy / /	cells/µL
Viral Load	mm dd yyyy / /	copies/µL

4. HIV Exposure Category: *Check one*

☐ Male who has sex with males (MSM)	☐ Heterosexual contact	☐ Not Reported
☐ Injection drug use (IDU)	☐ Receipt of blood transfusion, blood components, or tissue	☐ Other:
☐ Hemophilia/coagulation disorder	☐ Mother with or at risk for HIV infection (perinatal transmission)	

5. Medical Practitioner's Information (Physician, Nurse Practitioner or Physician Assistant):

Name:	Degree:	Phone #:		Fax #:
Street Address:		License Number & Issuing State:		NPI#:
City:	State:	Zip Code:	Signature:	Date: