APPLICATION FOR MEDICATION ASSISTANCE
Texas Department of State Health Services
ATTN: MSJA - MC 1873
PO Box 149347, Austin, TX 78714-9347
1-800-255-1090

Mail the completed application and copies of supporting documentation to the address listed above.

Make copies of your completed application and do not send any original documents, they will not be returned.

For help with your application, call your local community organization. For additional information on AIDS service organizations, case management services and community resources in your local area, please call 2-1-1.

If you have any questions, comments or concerns regarding the Texas HIV Medication Program (THMP) and this application for assistance, please call the program directly at 1-800-255-1090.

For additional information, including Frequently Asked Questions and downloadable copies of program documents, please visit the THMP web site at www.dshs.texas.gov/hivstd/meds/.

If approved for the program, you will need to update your eligibility at least every six months.

Important Information for Former Military Services Members: Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves, or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at veterans.portal.texas.gov.

Is your application complete?

THMP application, completed and signed within last 60 days
 Proof of Texas residency
 Medical Certification Form (MCF) from your doctor; MCF not necessary for recertification
 Front and back of your insurance card

Employed?
 At least two current consecutive paystubs
 Four paystubs if you’re paid weekly

A student?
 Proof of enrollment and financial aid

Working but paid in cash?
 Income verification form (from employer)

Are you self-employed?
 Federal Income Tax Return Form signed by you, a tax preparer, or proof of e-file

Receiving government benefits?
 Copy of current benefit awards letter

Supported by someone else?
 Supporter statement (from a person providing support)

Do you have Medicare Part D or insurance?

No

Yes

Complete THMP Copayment Assistance Form

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See www.dshs.texas.gov for more information on privacy notification. (Reference: Texas Government Code, Sections 522.021, 522.023, 559.003 and 559.004)
# PERSONAL INFORMATION

1. Last Name | First Name | Middle Name | Suffix (Jr., Sr., III)
---|---|---|---

2. Previous names (including maiden name, aliases, and name changes)

3. Do you have a SSN? Yes | No

Social Security Number: 
Tax ID (only if you do not have a SSN):

4. Date of Birth: mmm/dd/yyyy

5. Preferred Language: English | Spanish | Other:

6a. Current Gender: 
- Male 
- Female 
- Unknown
- Transgender: Male to Female
- Transgender: Female to Male

6b. Sex at Birth: 
- Male 
- Female 
- Unknown

6c. If applicable, are you currently pregnant? Yes | No
Due Date: 

7a. Ethnicity (check the one that best describes you):
- Hispanic (if Hispanic, please select subgroup)
  - Mexican, Mexican American, Chicano/a
  - Puerto Rican
  - Cuban
  - Another Hispanic, Latino/a or Spanish origin
- Non-Hispanic

- Asian (if Asian, please select subgroup)
  - Asian Indian
  - Korean
  - Chinese
  - Vietnamese
  - Filipino
  - Japanese
  - Other Asian
- Native Hawaiian or other Pacific Islander (please select subgroup)
  - Native Hawaiian
  - Guamanian or Chamorro
  - Samoan
  - Other Pacific Islander
- Other/Unknown
- American Indian/Alaska Native

8. Residential Street Address – (No P.O. Boxes or Rural Routes)

City | State | Zip Code
---|---|---

If you wish to have mail sent somewhere other than your residential address please provide an alternate mailing address:

9. Mailing Address - (P.O. Boxes and Rural Routes accepted here)

City | State | Zip Code
---|---|---

10. Home Phone Number (area code + number)

May we leave a voice mail? Yes | No

Work/Alternate Phone (area code + number)

May we leave a voice mail? Yes | No

If you are unavailable, are there any special instructions as to how we should leave a message for you?

# AUTHORIZATION OF RELEASE

11. Agency Worker (if applicable):
Agency Worker Phone & Fax #:
Direct Line: 
Fax: 
Agency:

11b. Alternate contact: The following individual(s) may speak on my behalf regarding my application and program status. These individuals may be family members or friends.

<table>
<thead>
<tr>
<th>Name of Person</th>
<th>Relation to You</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

Revised 1/2020
12. What is your current Marital Status:

- [ ] Single
- [ ] Widowed
- [ ] Divorced, Date:
- [ ] Separated, Date: (explanation required)
- [ ] Married/Common Law (provide spouse information below and complete page 4 for both yourself and your spouse)

If you are separated, please explain your current legal situation.

13. Spouse Name:  
Spouse SSN:  
Spouse Date of Birth:  
Is spouse also on program?  [ ] Yes  [ ] No

**IF UNDER 18 : GUARDIAN INFORMATION**

14. If you are under the age of 18 list parent or guardian information. Your parent or parents who live with you must complete the Income Section on the next page.

<table>
<thead>
<tr>
<th>A. Name of Parent or Guardian</th>
<th>B. Name of Other Parent or Guardian (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

**HOUSEHOLD INFORMATION**

15. Including yourself, how many people live in your home?

Complete the following table for your family. This only includes your legal or common-law spouse and children under 18 (including biological, adopted and step-children who live with you).

<table>
<thead>
<tr>
<th>Name</th>
<th>Age and Date of Birth (Birth Date Required for under 18)</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

16. Do you receive HOPWA/Section 8 housing assistance/subsidized housing?  [ ] Yes  [ ] No  
(If yes, include agency verification)

17. Is there anything else you would like to tell us about your living situation that could help clarify your application? For example, if you live with someone who supports you please explain your situation.

18. Have you recently been released or are you currently incarcerated in a jail or prison?  [ ] Yes  [ ] No

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Correctional ID #</th>
<th>Release Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, Agency Worker, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.
19. How do you support yourself? Please check ALL that apply below, for you and your spouse:

- I am employed
  - Include 2 current, consecutive pay stubs. If paid weekly, submit 4 consecutive pay stubs, for you AND your spouse.

- I work but I’m paid in cash
  - Have your employer complete the Income Verification Form. You may be required to submit a Tax Return Form signed by you, or a tax preparer, or proof of e-file, and/or bank statements.

- I have more than one job
  - Include 2 current, consecutive pay stubs for each job. If paid weekly, submit 4 consecutive pay stubs for each job. You may be required to submit a Tax Return Form signed by you, or a tax preparer, or proof of e-file.

- I am self-employed
  - Include a complete copy of your most recent Federal Income Tax Return Form. Your personal tax return form must be signed by you, or a tax-preparer, or must include proof of e-file.

- I’m under 18
  - Parent must fill out this page.

- I receive disability benefits, unemployment benefits, retirement/pension, VA benefits, or other awarded benefits
  - A copy of your benefit award letter or other official documentation showing the amount received on a regular basis.

- I’m a student
  - Submit proof of enrollment and financial aid from your school’s financial aid office.

- I don’t work. A relative, friend, or agency provides financial or housing support.
  - The person who supports you must complete the Supporter Statement (Page 7).
  - Provide proof of agency assistance you receive (if applicable).

- I am homeless
  - Provide proof of agency/shelter assistance you receive (if applicable).

- Other (please explain here)

20. Employment: We may verify your income with other sources such as the Texas Workforce Commission. Spouse information is required (common law or legally married). Parents of applicants under 18 must be complete this.

<table>
<thead>
<tr>
<th>Applicant or Parent A (if minor)</th>
<th>Spouse or Parent B (if minor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Status</td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>Full time</td>
</tr>
<tr>
<td>Part time</td>
<td>Part time</td>
</tr>
<tr>
<td>Self Employed</td>
<td>Self Employed</td>
</tr>
<tr>
<td>Unemployed</td>
<td>Unemployed</td>
</tr>
<tr>
<td>Temp/seasonal</td>
<td>Temp/seasonal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job 1: Employer (current or last)</th>
<th>Job Title (current or last)</th>
<th>End date (if unemployed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job 2: Employer (current or last)</th>
<th>Job Title (current or last)</th>
<th>End date (if unemployed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. Income and Benefits: Report MONTHLY gross income (the amount received before taxes/deductions). Submit proof of income!

<table>
<thead>
<tr>
<th>Wages, salary, commissions, tips, unemployment benefits</th>
<th>$</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Income (SSI or SSDI)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Retirement / Pension</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other Income (includes financial aid, alimony, investment income)</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
### HEALTH INSURANCE or MEDICATION ASSISTANCE

22. If you currently have health care coverage or health insurance, why are you applying for this program? *(Please check ALL that apply. Submit documentation from the insurance plan verifying your situation.)*  
- ☐ I do not have health care coverage or health insurance (proceed to question 23).  
- ☐ I need help paying my medication deductibles, medication copayments, or coinsurance expenses.  
- ☐ Private insurance (complete Copayment Assistance: Insurance on page 6)  
- ☐ Medicare (complete Copayment Assistance: Medicare on page 6)  
- ☐ My insurance does not cover prescription drugs or it doesn’t cover one or more HIV meds I need.  
- ☐ Coverage will end soon *(specify ending date)*:  
- ☐ Expenses have or are about to exceed the plan’s annual prescription cap.  
  - Amount of annual prescription cap: $  
- ☐ Other limitations on coverage or payment *(specify)*:

23. How are you currently getting medications for HIV (antiretroviral therapy)? *(check ALL that apply)*  
- ☐ I am not currently taking medications for HIV (antiretroviral therapy).  
- ☐ I am currently receiving medications through the Texas HIV Medication Program (THMP).  
- ☐ Private Health Insurance, Employer *(If a card is issued, submit a copy the front and back of the card.)*  
- ☐ Private Health Insurance, Individual *(If a card is issued, submit a copy the front and back of the card.)*  
- ☐ Patient Assistance Program (PAP)  
- ☐ Medicaid *(including Star and Star +)*  
- ☐ Medicare (Part A, Part B, Part C or Part D)  
- ☐ ACA, “ObamaCare” or Marketplace Plans  
- ☐ Indigent Care *(City/County plans such as MAP, Gold Card, Carelink or local agency assistance)*  
- ☐ Veteran’s Affairs *(VA)*  
- ☐ Other:

24. Have you previously had any health insurance: ☐ Yes ☐ No  
   - If yes, please list name and date coverage ended. **If your insurance terminated in the last 90 days, submit proof of termination.**
   - Insurance Name:  
   - End Date:  
   - Insurance Name:  
   - End Date:

### ADDITIONAL INFORMATION

25. Is there anything you would like to clarify on this application? Please use this space to provide any additional information that may help THMP process your application. Attach additional pages if needed.

### THMP ASSISTANCE AGREEMENT

**IMPORTANT – READ, SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION:**

1) I understand that this application is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program (THMP) and (3) attests that I reside in the State of Texas.  
2) I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; if my/our residential or mailing address changes; or if my/our marital, household or insurance status changes.  
3) I understand that the THMP may request verification of the information I have provided in order to process my application, and also at any time thereafter.  
   - I also understand that the processing of my application may be delayed until such requested verification is received.  
4) I understand that the THMP may verify information provided on this application with data resources made available to the program for the purpose of eligibility determination.  
5) I understand that deliberately omitting or giving false information could cause me to be removed from the THMP and/or criminally prosecuted.  
6) I understand that the THMP reserves the right to limit enrollment based upon availability of funds.  
7) I understand that the THMP is required to recertify my eligibility status at least every six months in order to continue receiving services.  
8) I understand that I must order HIV medications from this program on a monthly basis and that I will be dropped from the program if I don’t order medications for six consecutive months.  
9) I understand that my information will be shared with my HIV service providers and Agency Workers. I will contact THMP if I want an exception to be made.

**Signature of Applicant (please print and sign) Date (required)**

**Signature of Parent (if applicant is under 18 years of age) (please print and sign) Date (required)**
**COPAYMENT ASSISTANCE – Complete if you have:**
Medicare part D (State Pharmaceutical Assistance Program - SPAP)
Or Private Insurance (Texas Insurance Assistance Program - TIAP)

Applicants with MEDICARE or PRIVATE INSURANCE should fill out this form in addition to the main THMP form. The SPAP provides help with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. The TIAP provides help with co-pays, coinsurance and premiums associated with COBRA plans and private insurance.

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**DO YOU HAVE MEDICARE? FILL OUT THIS SECTION FOR SPAP**

Your Medicare Number

Are you enrolled in a Medicare Prescription Drug Plan (Part D)?  
- No  
- Yes (if yes, please provide plan information below)

Rx Plan Name:  

Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration?  
- No  
- Yes (please indicate application status below)

Low Income Subsidy/Extra Help Application Status  

- Approved, 100% Assistance  
- Denied Assistance (attach a copy of pre-decisional or denial letter)  
- Approved, partial assistance (attach copy of approval letter)  
- Awaiting determination, application date:

**DOB YOU HAVE INSURANCE? FILL OUT THIS SECTION FOR TIAP**

Are you enrolled in a private insurance plan?  
- No  
- Yes (if yes, please provide plan information below)

Plan Name:  

Do you have an Affordable Care Act (ACA) Marketplace Plan?  
- Yes  
- No

**PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD**

Is this an Individual, Non-ACA, Off Marketplace Plan?  
- Yes  
- No

Is this plan offered through an employer?  
- Yes  
- No

If you have COBRA or may be eligible for COBRA, please submit copies of your COBRA paperwork (TIAP may assist with COBRA Premiums and Copayments):

Have you already submitted your COBRA paperwork?  
- No  
- Yes date submitted:

COBRA Administrator's Phone Number:

COBRA Election/Enrollment Due Date:

COBRA Initial Payment Due Date:

COBRA Account #:

**COPAYMENT ASSISTANCE AGREEMENT**

**IMPORTANT – READ, SIGN AND DATE THE FOLLOWING COPAYMENT ASSISTANCE AGREEMENT:**

1) I understand that it is my responsibility to (a) enroll in a Medicare Prescription Drug Plan and apply for the Low Income Subsidy if I have Medicare, (b) maintain my enrollment in an insurance plan or a Medicare Prescription Drug Plan, and (c) pay the monthly prescription drug plan premium directly to the prescription drug plan.

2) If I have private insurance, it is my responsibility to inform the program of any changes in my private insurance benefits or COBRA.

3) I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; if my/our residential or mailing address changes; my/our marital, or household status changes; or my Medicare benefits are terminated, I lose my insurance coverage or my eligibility for Medicaid or Medicare changes.

4) I understand that the THMP reserves the right to limit enrollment based upon availability of funds.

5) I understand that the THMP is required to recertify my eligibility status at least every six months in order to continue receiving services.

6) I understand that information may be shared with THMP staff and my insurance plan. I hereby give consent to the THMP to obtain or release my demographic, medical and/or insurance coverage information with other entities as necessary.

7) I agree to participate in a periodic follow up by the THMP Insurance Assistance Program staff to determine the effectiveness of the program.

8) I understand that I must order HIV medications from this program on a monthly basis and that I will be dropped from the program if I don't order medications for six consecutive months.

9) I understand that this is a legal document. My signature (a) attests that all the information given is true and correct, (b) authorizes the release of my medical information to the THMP, and (c) attests that I reside in the State of Texas.

Signature of Applicant (please print and sign)  

Date (required)

Signature of Parent (if applicant is under 18) (please print and sign)  

Date (required)
FORM A: SUPPORTER STATEMENT

If an applicant has no income or is unable to provide any documentation showing how they manage, this form can be used as documentation. This form must be completed, signed, and dated by the person providing support within the last 60 days; it **should not** be filled out by the person applying for the program.

I, ____________________________________________, certify that I currently support

______________________________________________, who resides at the following address: ________________________________________________

(person you support's street address, city, state, & zip code)

I have supported him/her since ____________________________. My relationship to the applicant is ____________________________.

(examples: parent, spouse, roommate, friend, sister, etc.)

The type of support I provide is (check all that apply):

- [ ] Room
- [ ] Food/Clothing
- [ ] Rent/Mortgage
- [ ] Utility Bills
- [ ] Cash Assistance in the amount of $________ per month
- [ ] Other:

Additional explanation (if necessary):

I can be reached at the following phone number(s) to verify this information:

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

Signature of Supporter *(please print and sign)*  

Date *(required)*
# FORM B: INCOME VERIFICATION

This form should be used **only when no supporting income documentation is available.** If paystubs are available to the employee copies **must** be submitted. This should be signed and dated within the last 60 days by the employer only.

## I. Employee Information

Employee Name:

Employee Address:

## II. Employer Contact Information

Business Name:

Business Address:

Business Phone Number:

Contact Name:  
Contact Phone Number:

## III. Employee Income

Type of work performed by the employee:

First Day of Employment:  
Last Day of Employment (if applicable):

Average number of hours worked per week:

Method of payment *(check one)*:

- [ ] Cash  
- [ ] Personal check  
- [ ] Payroll check  
- [ ] Other (please specify)

Frequency of payment *(check one)*:

- [ ] Weekly  
- [ ] Biweekly  
- [ ] Semi-monthly  
- [ ] Monthly  
- [ ] Daily  
- [ ] Other (please specify)

Gross earnings $ per pay period

Estimated amount of **weekly** tips or commissions: $ per week

## IV. Employee Health Coverage

Is employer-sponsored health coverage offered?  
[ ] Yes  
[ ] No

If yes, is/was this employee enrolled in health coverage?  
[ ] Yes  
[ ] No

## V. Additional Information

Will there be any changes to this person’s employment in the next few months?

## VI. Certification

I verify that the above information is true and correct to the best of my knowledge.

**Signature of Employer** (please print and sign)  
**Date** (required)
TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN)  Texas HIV Medication Code (if known)
The information requested is necessary to determine the patient’s eligibility for program-supplied, HIV-related
therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department
of State Health Services; personal identifying info is never released.

*** Both pages are required. ***

PATIENT INFORMATION
Full Name: ________________________________ Apt. #
Mailing Address: ____________________________ Phone #: (____) __________
City, State, Zip: ____________________________ Social Security Number: __________
Date of Birth: ____________________________  Social Security Number: __________
          Month    Day    Year
Requested Pharmacy: __________________________

I hereby certify that this patient has been diagnosed with HIV, and I am reporting the following viral load and CD4
count:

<table>
<thead>
<tr>
<th>Plasma RNA Viral Load:</th>
<th>Test Date:</th>
<th>Current CD4 Count:</th>
<th>Test Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>copies/ml</td>
<td>/ /</td>
<td></td>
<td>/ /</td>
</tr>
</tbody>
</table>

*REQUIRED* Is this patient new to any medications in this antiretroviral therapy regimen?
(check one) Yes ☐  No ☐

On the following page, mark the appropriate box to specify supply quantity for each medication prescribed.
Medications marked n/a indicate the medication is not eligible for a 90-day supply. Some medication strengths or
formulations are excluded from 90-day availability. Please refer to the THMP Medication Formulary and Maximum
Quantities Table for details. Providers should reserve prescribing a 90-day medication supply for people on stable
medication regimens; medications that are new or have changed in dose for a patient are not eligible to be
dispensed as 90-day supply.

*Note: Combivir, Descovy, Dovato, Evotaz, Epzicom, Prezcobix, Truvada, & Juluca each count as 2 ARVs; Atripla,
Complera, Odefsey, Trizivir, Triumeq, Biktarvy, & Delstrigo each count as 3 ARVs; Stribild, Symtuza, and Genvoya
each count as 4 ARVs. HLA-B*5701 test result of negative is required for treatment-naïve patients starting
medications that contain abacavir (Ziagen, Epzicom, Trizivir, or Triumeq).

I certify that this patient is being prescribed the medications selected on the attached page.

PHYSICIAN SIGNATURE: ________________________________ TX MD/DO LICENSE #: ______________
PRINTED NAME OF PHYSICIAN: ________________________________
OFFICE ADDRESS: ________________________________
TELEPHONE: ________________________________ FAX: ________________________________ DATE: ___/___/____

***NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 533-3171.

If this form is completed as part of an initial program application, it should be mailed to:
Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347
<table>
<thead>
<tr>
<th>Qty Prescribed (days)</th>
<th>Qty Prescribed (days)</th>
<th>Qty Prescribed (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 30</td>
<td>90 30</td>
<td>90 30</td>
</tr>
<tr>
<td>n/a</td>
<td>□ azithromycin OR</td>
<td>□ or □ Clarithromycin (choose one)</td>
</tr>
<tr>
<td>n/a</td>
<td>□ Dapsone OR n/a</td>
<td>□ or □ pentamidine OR □ or □ SMZ/TMP (choose one)</td>
</tr>
<tr>
<td>n/a</td>
<td>□ acyclovir OR</td>
<td>□ or □ famciclovir OR □ or □ Valacyclovir (choose one)</td>
</tr>
<tr>
<td>n/a</td>
<td>□ Gynazole (butoconazole) OR n/a □ or □ Monistat (tioconazole) OR n/a □ or □ terconazole topical (choose one)</td>
<td></td>
</tr>
<tr>
<td>□ or □ fluconazole OR</td>
<td>□ or □ itraconazole OR □ or □ Voriconazole (choose one)</td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>□ atovaquone (Mepron)</td>
<td>□ or □ clindamycin</td>
</tr>
<tr>
<td>n/a</td>
<td>□ ethambutol</td>
<td>□ or □ clotrimazole troche</td>
</tr>
<tr>
<td>n/a</td>
<td>□ leucovorin calcium tablets n/a □ or □ isoniazid</td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>□ megestrol acetate oral susp n/a □ or □ nystatin oral susp</td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>□ Daraprim (pyrimethamine) n/a □ or □ Oravig (miconazole)</td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>□ ritabutin</td>
<td>□ or □ prednisone</td>
</tr>
<tr>
<td>□ or □ Valcyte (valganciclovir) n/a □ or □ primaquine phosphate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>□ Egrifta (tesamorelin acetate P/F) n/a □ or □ rifampin</td>
<td></td>
</tr>
<tr>
<td>□ or □ Mytesi (crofelemer)</td>
<td>□ or □ sulfadiazine</td>
<td></td>
</tr>
<tr>
<td>n/a</td>
<td>□ Baraclide</td>
<td>□ or □ Vemlidy</td>
</tr>
<tr>
<td>□ or □ Lisinopril</td>
<td>□ or □ Hydrocholorothiazide □ or □ Amlodipine</td>
<td></td>
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<tr>
<td>□ or □ Metoprolol Tart</td>
<td>□ or □ Metformin □ or □ Trazodone</td>
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<tr>
<td>□ or □ Duloxetine</td>
<td>□ or □ Gabapentin □ or □ Sertraline</td>
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<tr>
<td>n/a</td>
<td>□ Atorvastatin</td>
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**ANTIRETROVIRALS RX:** MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

<table>
<thead>
<tr>
<th>Qty Prescribed (days)</th>
<th>Qty Prescribed (days)</th>
<th>Qty Prescribed (days)</th>
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<tr>
<td>90 30</td>
<td>90 30</td>
<td>90 30</td>
</tr>
<tr>
<td>n/a</td>
<td>□ Aptivus (TPV)</td>
<td>□ or □ Atripla (ABC/FTC/TDF)</td>
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<tr>
<td>□ or □ Combivir (AZT/3TC)</td>
<td>□ or □ Complera (FTC/RPV/TDF)</td>
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<tr>
<td>□ or □ Descovy (FTC/TAF)</td>
<td>□ or □ Dovato (DTG/3TC)</td>
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<tr>
<td>□ or □ Emtriva (FTC)</td>
<td>□ or □ Epivir (3TC)</td>
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<tr>
<td>□ or □ Evotaz (ATV/c)</td>
<td>□ or □ Fuzeon</td>
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<tr>
<td>□ or □ Intelance (ETR)</td>
<td>□ or □ Invirase (SQV)</td>
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<tr>
<td>□ or □ Isentress HD (RAL)</td>
<td>□ or □ Juluca (DTG/RPV)</td>
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<tr>
<td>□ or □ Lexiva (FPV)</td>
<td>□ or □ Norvir (ritonavir)</td>
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<tr>
<td>□ or □ Pifeltro (DOR)</td>
<td>□ or □ Prezcobix (DRV/c)</td>
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<tr>
<td>□ or □ Reyataz (ATV)</td>
<td>□ or □ Selzentry (MVC)</td>
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<td>□ or □ Sustiva (EFV)</td>
<td>□ or □ Symtuza (c/DRV/FTC/TAF)</td>
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<tr>
<td>□ or □ Trumeq (DTG/ABC3TC)</td>
<td>□ or □ Trizivir (AZT/ABC/3TC)</td>
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<tr>
<td>□ or □ Tybost (cobicistat)</td>
<td>□ or □ Viracept (NFV)</td>
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<td>□ or □ Viread (TDF)</td>
<td>□ or □ Vitekta (EVG)</td>
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<tr>
<td>n/a</td>
<td>□ zidovudine (AZT)</td>
<td>□ or □ Ziagen (ABC)</td>
</tr>
</tbody>
</table>

Revised 1/2020