



VIRGINIA DEPARTMENT OF HEALTH VA MAP MEDICATION EXCEPTION FORM

PATIENT NAME (Last, First, MI):			
D.O.B. (mm/dd/yy):		AGE:	
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
ADDRESS	CITY	STATE	ZIP
RACE/ETHNICITY: <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> African American/Black (non-Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> American Indian, Aleutian, Eskimo <input type="checkbox"/> Unknown			
HEALTH DEPARTMENT PHONE #		HEALTH DEPARTMENT FAX #	
LOCAL HEALTH DEPARTMENT VA MAP CONTACT PERSON:			
PRESCRIBING PHYSICIAN NAME:			
PHYSICIAN PHONE #:		PHYSICIAN FAX #:	
FORM COMPLETED BY (Name):			
TITLE:		DATE (mm/dd/yy):	

MEDICATION REQUESTED:
REASON FOR EXCEPTION REQUEST (PLEASE REFER TO EXCEPTION CRITERIA):

Specify other anti-retroviral medications patient is currently on

NAME OF MEDICATION	DOSE	DATE STARTED	DATE DISCONTINUED

LABORATORY HISTORY [Please start with the most current results (give at least two (2) results if available)]

VIRAL LOAD RESULTS*	DATE	CD4 COUNT RESULTS	DATE

VDH USE ONLY

Request Approved Request Denied

Rationale: _____

Signature: _____ **Date:** _____

Date of Positive CCR5 assay/Maraviroc Approval: _____

Fax to: Central VA MAP office at (804) 864-8050 [Phone: (855) 362-0658]

