GENERAL REVENUE (GR) SHORT-TERM MEDICATION* ASSISTANCE
THROUGH THE JMH SPECIALTY PHARMACY
for the Florida Department of Health and Ryan White Part A/MAI Programs in Miami-Dade County

Referral Start Date:_____ **Referral Stop Date*:_____**
Maximum referral length is two (2) months and is limited to GR Prescription Drug Formulary medications only.

REFERRAL FROM:

Part A/MAI Medical Case Manager Name: _____
Agency Name: _____
Phone: _____ **Fax: _____**

MEDICATIONS NEEDED:

List prescribed antiretroviral (ARV), opportunistic infection (OI), or other medication(s) needed per this referral:
(limited to medications listed on the most current GR Prescription Drug Formulary only)

_____
_____

Prescribing Practitioner Name: _____
Prescribing Practitioner Phone Number: _____

Special Instructions: _____

CLIENT INFORMATION: **CIS#: _____**

Name: _____ **DOB: ____/____/____**
Current SFAN# or Jackson "I01" Card #: _____
Social Security #: _____
Street Address: _____
City: _____ **Zip: _____** **Phone Number: _____**

REASON FOR ASSISTANCE: *(Check one)*

- ☐ **ADAP application or re-certification process pending current labs**
- ☐ **ADAP application or re-certification process pending original prescription**
- ☐ **ADAP medical exception/exemption request pending**
- ☐ **ADAP re-enrollment is past due and requires emergency supply of medications to ensure adherence to treatment regimen**
- ☐ **ADAP application/enrollment pending (specify reason: _____)**
- ☐ **Affordable Care Act (ACA) binder payment for premium delayed *(this option is not applicable for access to ARVs and OIs when the premiums would be paid by ADAP)***

I attest that all documentation provided with this referral is complete, accurate and true. I hereby authorize my medical case manager to provide this information to the Public Health Trust of Miami-Dade County / Jackson Health System for the purpose of obtaining short-term, emergency access to ARV, OI, or other medication(s) that are listed on the most current GR Prescription Drug Formulary while my enrollment into the ADAP program or ACA premium payment is pending.

Client's Signature: _____ **Date: ___/___/___**

Required Documentation: This referral must be accompanied by proof of HIV positive status, financial eligibility, and permanent Miami-Dade County residency. Please see the accompanying Client Eligibility Documentation Checklist for a list of acceptable eligibility documents and check the type of proof provided with this referral.

Medical Case Management Supervisor's Signature: _____ **Date: ___/___/___**