Applying for third line antiretroviral (ARV) therapy

In patients who have failed on second line treatment, an application for third line ARV treatment needs to be sent to the central committee for review. Here's how it's done:

1. **Download** the PDF. Click here to go the link. **Please do not print out the document to complete by hand.**

2. **Open** the PDF document using Adobe Reader. Ensure you have the latest version of the form may not work properly (see below for link and installation instructions).

3. This is an editable PDF. **Fill in** all fields. The minimum required fields will be highlighted. Please click on each field and enter the required patient information.

4. Once you have completed the document please **save** it to your computer by clicking the save icon on the top left of the screen. Save it using the patient name and surname as a unique identifier.

5. **Submit.** Close Adobe and attach the completed and renamed application form to an email and submit it to the following email address: **TLART@health.gov.za**

Please note that, In order to open the application form, you will need the latest Adobe Reader installed on your computer. If you don't have it, please download it from the Adobe website.

For any queries please contact the committee at **TLART@health.gov.za**

APPLICATION - THIRD LINE ANTIRETROVIRAL THERAPY

PLEASE ENSURE ALL FIELDS ARE COMPLETED BEFORE SUBMITTING

Patient First Name					
Patient Surname					
Date of Birth day/month/year		**Patient number**			
Identity number		**Age**		**Gender**	
Weight		**BMI** (kg/m^2)		***Height (child)***	

FACILITY DETAILS

Facility Name	
Province	
Doctor In Charge Of Patient/ Authorised Prescriber	
Doctor's Contact Number	
Doctor and Pharmacist Email Addresses	

		Date day/month/year	

PAST MEDICATION HISTORY

Timelines day/month/year		**Past Regimens Only**	**Reason for discontinuation**	**Concurrent TB therapy?**
Date started				
Date stopped				
Date started				
Date stopped				
Date started				
Date stopped				
Date started				
Date stopped				

Reason for discontinuation codes: *SE = Side effect, F= Failure, FC = Formulary change, NC = Non adherent*

CURRENT REGIMEN ONLY

Date started day/month/year		**Regimen**	

CHILDREN: PMTCT HISTORY

Was the mother on therapy during pregnancy or breastfeeding?	
What treatment did the mother take and for how long?	
Was child breastfed?	
Did child receive any ARV at birth/ after birth/ during breastfeeding? State ARV and duration	

ADHERENCE IN LAST 3 – 6 MONTHS	
Regular clinic attendance	
On-time pharmacy refill	
Correct pill counts	
Treatment partner observes taking of medication	
Alcohol / drug abuse	
Severe GIT or other side effects experienced	
If adherence problem, what interventions were undertaken to address the issue?	

CD 4 COUNT				**VIRAL LOAD**		
DATE day/month/year		**RESULT**	***Children CD4 %***	**DATE** day/month/year		**RESULT**
Date:				Date:		
Date:				Date:		
Date:				Date:		

Most recent available tests		**Date**
Hb (g/dL)		
ALT (U/L)		
Creatinine (µmol/L)		
Creatinine Clearance (mL/min/1.73 m^2)		
White cell count (x 10^9/L)		
Hepatitis B status (HbsAg pos/neg)		

Results of Viral Resistance Test - submit together with application to:

TLART@HEALTH.GOV.ZA

Concomitant medication and indication	
Children: *Is child able to swallow a tablet?*	

Please ensure that laboratory resistance test is submitted with this form!
For office use only:
Date received:
Recommendation: Date: