BFP | BROADWAY FAMILY PHARMACY

*To fill out this form online, please scan the QR code.

FAX OR ESCRIPT ALL PRESCRIPTIONS TO

Broadway Family Pharmacy
510 Amsterdam Ave, STR1 | New York, NY 10024-3935
Toll Free Phone & Fax: 888-609-2064
Email: prxpny@340bpharm.com

**Licensed in NY, AK, AL, AZ, CA, CT, CO, DC, FL, GA, IA, ID, IL, IN, KS, KY, LA, MA, ME, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV and WY*

CLINIC NAME: ☐ 340B Regular ☐ PREP ☐ T&T

TODAY'S DATE: 340B Eligible: ☐ Yes ☐ No

DELIVERY INFORMATION PCP:

☐ Patient's Address:

☐ Prescriber's Address:

☐ Other Address:

CURRENT PHARMACY INFORMATION

Pharmacy: _____ Phone: _____ Fax: _____

Address:

PATIENT DEMOGRAPHICS (REQUIRED)

Last Name: First Name: Middle Name:

Preferred Name: Birth Date: ___/__ _/_____ Pronouns:

Sex [Check One]: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other:

Street Address: P.O. Box City, State, Zip:

Phone Number: (Home/Cell) Emergency Contact: Emergency Contact Phone:

Please attach copy of driver's license or photo ID front and back as well as Insurance Cards front and back (Including prescription benefits)

Policy Insurance: Patient ID: Rx Group Number:

PCN: BIN: Subscriber's Name:

Patient Relationship to Subscriber [Check One]: ☐ Self ☐ Spouse ☐ Child ☐ Other: ☐ Check to Indicate Front/Back of Insurance Card is Attached

PATIENT CLINICALS (REQUIRED) ***Please send additional sheet if needed for complete medication list**

Patient's Diagnosis [include ICD-10]:

Patient's Other Medical Conditions [include ICD-10]: ☐ No other medical conditions

Any known allergies or sensitivities: ☐ No Known Allergies

Pertinent Medical History: ☐ No additional Information

Is patient able to self-administer the medication prescribed? ☐ Yes ☐ No If "No", provide details:

PrEP: Date of last negative result: **HIV**: Current CD4 (T-cell) count: **HIV**: Resistance test result:

HIV: Date of last positive result: **HIV**: Current viral load: **HCV**: Current viral load:

HCV: Genotype: **HCV**: IL-28B: **HCV**: Liver Fibrosis:

Other Medications Including OTCs & Supplements	*Dose, Route, Frequency*	*Diagnosis*

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRACTICES, AND PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THEM

Patient / Guardian Signature: **Date:**

BY SIGNING BELOW, I AUTHORIZE BROADWAY FAMILY PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

Patient / Guardian Signature: **Date:**