PRXP | PRxP OF CA PHARMACY

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

**FAX OR ESCRIPT ALL PRESCRIPTIONS TO**

**PRXP of CA**
*4345 E Lowell Street, Suites C & D | Ontario, CA 91761*
**Toll Free Phone & Fax: 888-505-1485**
**Email: prxpca@340bpharm.com**
**Licensed in CA, AZ, IL, NY, OH, PA, and WA*

| | | | |
|---|---|---|---|
| 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 PRXP OF CA TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

**Patient / Guardian Signature:** **Date:**