



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

**FAX OR ESCRIPT ALL PRESCRIPTIONS TO
iCARE RX, LLC**

14447 Country Walk Dr | Miami, FL 33186

Toll Free Phone & Fax: 888-606-7471

Email: icarerx@340bpharm.com

*Licensed in FL

CLINIC NAME:	<input type="checkbox"/> 340B Regular	<input type="checkbox"/> PREP	<input type="checkbox"/> T&T
TODAY'S DATE:	340B Eligible:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DELIVERY INFORMATION		PCP:	
<input type="checkbox"/> Patient's Address:			
<input type="checkbox"/> Prescriber's Address:			
<input type="checkbox"/> 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]: <input type="checkbox"/> Male <input type="checkbox"/> Female		Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> 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]: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____ <input type="checkbox"/> 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]:		<input type="checkbox"/> No other medical conditions
Any known allergies or sensitivities:		<input type="checkbox"/> No Known Allergies
Pertinent Medical History:		<input type="checkbox"/> No additional Information
Is patient able to self-administer the medication prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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

Patient / Guardian Signature:

Date:

Patient / Guardian Signature:

Date: