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

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:**