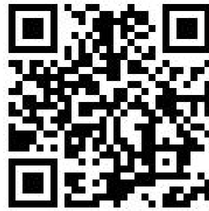

To fill out this form online, please scan the QR code.

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: ny_pharmacists@340bpharm.com

CLINIC NAME:	☐ 340B Regular	☐ PREP/STD
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:**