iCP | iCARE Rx PHARMACY

*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

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 ICARE RX PHARMACY TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

Patient / Guardian Signature: **Date:**