PRXP | PHYSICIANS RX PHARMACIES

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

**FAX OR ESCRIPT ALL PRESCRIPTIONS TO**

**Physicians RX Pharmacy**
9701 Apollo Drive, #400 | Largo, MD 20774

**Toll Free Phone & Fax: 888-330-2153**
**Email: prxpgreenbelt@340bpharm.com**

| | | |
|---|---|---|
| CLINIC NAME: | ☐ 340B Regular | ☐ PREP/STD |
| TODAY'S DATE: | 340B Eligible: | ☐ Yes ☐ No |
| ***DELIVERY INFORMATION (REQUIRED)*** | PCP: | |
| ☐ Patient's Address (See Address information under PATIENT DEMOGRAPHICS Section) | | |
| ☐ Other Address: | | |
| ***CURRENT PHARMACY INFORMATION*** | Pharmacy: | Phone: Fax: |

| | | |
|---|---|---|
| ***PATIENT DEMOGRAPHICS (REQUIRED)*** | Address: | |
| Last Name: | First Name: | Middle Name: |
| Preffered Name: | Birth Date: | Pronouns: |
| Sex (check one): ☐ Male ☐ Female | Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other | |
| Street Address: | P.O. Box: | City, State, Zip: |
| Email Address (if available): | Phone Number: | 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 on this form or ERx]: | |
| Patient's Other Medical Conditions: | ☐ 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: |

| *Other Medications Including OTCs & Supplements* | *Dose, Route, Frequency* | *Diagnosis* |
|---|---|---|
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|---|---|---|
| ***PATIENT CLINICALS (Optional)*** | | |
| 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: |

***SIGNATURE REQUIRED IF the Prescription is being delivered to the delivery address noted on this form***

I AUTHORIZE THE PHARMACY TO DELIVER TO THE DELIVERY ADDRESS NOTED ON THIS FORM.

Patient/Guardian/Healthcare Provider Signature: Date:

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

Patient/Guardian Signature: Date: