*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/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:
	Address:

PATIENT DEMOGRAPHICS (REQUIRED)

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*

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 PRXP OF CA TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED. Patient/Guardian Signature: Date: