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/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: