Broadway Family Pharmacy

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

ENROLLMENT FORM

FAX OR ESCRIPT ALL PRESCRIPTIONS TO

Broadway Family Pharmacy
601 Amsterdam Ave. | New York, NY 10024
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 (REQUIRED)	PCP:	
☐ PATIENTS 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:	
Preferred 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 CLINCALS (REQUIRED)	***Please send additional sheet if needed for complete medication list***
Patient's Diagnosis [include !CD-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 CLINCALS (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: