



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

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

ENROLLMENT FORM

CLINIC NAME:		<input type="checkbox"/> 340B Regular	<input type="checkbox"/> PrEP/STD
TODAY'S DATE:		340B Eligible:	<input type="checkbox"/> Yes <input type="checkbox"/> No
DELIVERY INFORMATION (REQUIRED)		PCP:	
<input type="checkbox"/> PATIENTS ADDRESS (See Address information under PATIENT DEMOGRAPHICS Section)			
<input type="checkbox"/> 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): <input type="checkbox"/> Male <input type="checkbox"/> Female		Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other:	
Street Address:		P.O. Box:	City, State, Zip:
Email Address (if available):		Phone Number:	Emergency Contact: Emergency Contact Phone:
<i>*Please attach copy of driver's license or photo ID front and back as well as Insurance Cards front and back (Including prescription benefits)*</i>			
Policy Insurance:		Patient ID:	Rx Group Number:
PCN:		BIN:	Subscriber's Name:
Patient Relationship to Subscriber (check one): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		<input type="checkbox"/> Check to Indicate Front/Back of Insurance Card is Attached	
PATIENT CLINICALS (REQUIRED)		<i>*Please send additional sheet if needed for complete medication list</i>	
Patient's Diagnosis [include ICD-10 on this form or ERx]:			
Patient's Other Medical Conditions:			<input type="checkbox"/> No other medical conditions
Any known Allergies or Sensitivities:			<input type="checkbox"/> No known allergies
Pertinent Medical History:			<input type="checkbox"/> No additional information
Is patient able to self administer the medication prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> 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		BY SIGNING BELOW, I AUTHORIZE PRXP OF CA TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.	
I AUTHORIZE THE PHARMACY TO DELIVER TO THE DELIVERY ADDRESS NOTED ON THIS FORM.			
Patient/Guardian/Healthcare Provider Signature:		Date:	Patient/Guardian Signature: Date: