



FAX OR ESCRIPT ALL PRESCRIPTIONS TO

iCARE RX, LLC

14447 Country Walk Dr | Miami, FL 33186

Toll Free Phone & Fax: 888-606-7471

Email: icarerx@340bpharm.com

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

ENROLLMENT FORM

PATIENT DEMOGRAPHICS (REQUIRED)		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:
		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:	
<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): ☐ Self ☐ Spouse ☐ Child ☐ Other		☐ 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: ☐ 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			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:	