



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

# ENROLLMENT FORM

FAX OR ESCRIPT ALL PRESCRIPTIONS TO

**Physicians RX Pharmacy**  
9701 Apollo Drive, #400 | Largo, MD 20774  
Toll Free Phone & Fax: 888-330-2153  
Email: prxpgreenbelt@340bpharm.com

|  |                                       |  |
|--|---------------------------------------|--|
| 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 |
| <b>DELIVERY INFORMATION (REQUIRED)</b>   | PCP:                                  |  |
| <input type="checkbox"/> PATIENTS ADDRESS (See Address information under PATIENT DEMOGRAPHICS Section) |                                       |  |
| <input type="checkbox"/> OTHER ADDRESS:  |                                       |  |
| <b>CURRENT PHARMACY INFORMATION</b>  | Pharmacy:                             | Phone: Fax:  |

|  |                  |  |                          |
|--|------------------|--|--------------------------|
| <b>PATIENT DEMOGRAPHICS (REQUIRED)</b>   | Address:         |  |                          |
| 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: |

*\*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): <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)** *\*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 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:         |

|   |  |
|---|--|
| <b>*SIGNATURE REQUIRED IF the Prescription is being delivered to the delivery address noted on this form*</b> | BY SIGNING BELOW, I AUTHORIZE PHYSICIANS RX PHARMACY 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: _____   | Patient/Guardian Signature: _____  |
| Date: _____   | Date: _____  |