



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

ENROLLMENT FORM

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:	<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:

PATIENT DEMOGRAPHICS (REQUIRED)	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:
Authorized Representative (Covered Entity Name or Provider Group) Name:	Phone:	Email:
<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 CLINCALS (REQUIRED)	<i>*Please send additional sheet if needed for complete medication list</i>	
Patient's Diagnosis [include !CD-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:	
<i>Other Medications Including OTCs & Supplements</i>	<i>Dose, Route, Frequency</i>	<i>Diagnosis</i>

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:

By signing below, I authorize the release of PHI needed to process claims for my medication, including medical and insurance benefit information. I also authorize the pharmacy to contact my current pharmacy to transfer my prescriptions, deliver medication to the address listed on this form, contact my authorized representative if I cannot be reached to confirm shipping details, and bill my insurance company for prescriptions filled on my behalf.

Patient/Guardian/Representative Signature: _____ Date: _____ ***SIGNATURE REQUIRED**