

PRXP of CA

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1 PATIENT INFORMATION

LEGAL NAME (LAST, FIRST, MI)

DATE OF BIRTH

PHONE

ADDRESS

CITY / STATE / ZIP

2 INSURANCE & FINANCIAL

Please attach clear copies of the patient's insurance card(s).

☐ Front attached ☐ Back attached ☐ Secondary

INSURANCE CARD ATTACHMENT

Send front/back with this form by the pharmacy's secure method.

3 DELIVERY / STC INFORMATION

Complete only if needed for pharmacy workflow / STC.

☐ Patient ☐ Office - first dose ☐ Office - all doses

ALTERNATE DELIVERY ADDRESS

DATE / INSTRUCTIONS

4 BASIC CLINICAL INFORMATION

ALLERGIES (INCLUDE NKDA)

OTHER KNOWN MEDICATIONS / CONDITIONS

Basic info is enough (example: lisinopril / hypertension).

5 HIV / PrEP ASSESSMENT

☐ HIV treatment ☐ PrEP ☐ PEP

PREVIOUS HIV / PREP THERAPY

REASON THERAPY WAS CHANGED / STOPPED / FAILED

RESISTANCE TEST / DATE (IF KNOWN)

ADDITIONAL HIV / PREP NOTES

6 COVERED ENTITY NAME

COVERED ENTITY NAME

☐ RW ☐ STD ☐ OTHER

PROVIDER / CE REP SIGNATURE

DATE

ADDITIONAL PHARMACIST NOTES

ATTACH: insurance cards (front/back).

Complete only fields applicable to this patient. Prescription requirements vary by state and payer.