Patient Enrollment

DATE	NEEDS BY DATE	SHIP TO: ❏ PATIENT ❏ OFFICE - FIRST DOSE ❏ OFFICE - ALL DOSES ❏ OTHER:
REFERRED BY		TEL

PATIENT INFORMATION

ALL INFORMATION IS CONFIDENTIAL AND USED FOR CLINICAL PURPOSES ONLY

Patient Name		Preferred Name	
Main Phone	Alternative Phone	Date of Birth	Social Security #
Address		City, State, Zip	
Sex ❏ Male ❏ Female ❏ Intersex ❏ MtF Female ❏ FtM Male ❏ other:			
Gender Identity ❏ Male ❏ Female ❏ Transgender ❏ Non-Binary ❏ other:			Pronouns
Allergies			❏ HIV ❏ PrEP

PRESCRIBER INFORMATION

Prescriber Name	
Address	City, State, Zip
Office Contact	Phone

INSURANCE

PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

Ryan White Eligible ❏ Yes ❏ No	Ryan White Eligibility Period	340B Eligible ❏ Yes ❏ No	❏ Do not bill Medicaid as Secondary
❏ Private Insurance ID#:		❏ Medicaid ID#:	
❏ Medicare Part D ID#:		❏ Other: ID#:	

FINANCIAL ASSISTANCE

❏ Meets requirements for clinic's financial assistance program	❏ Clinic Pays All ❏ Patient Pays All at 340B Price ❏ Clinic Pays Copays

PRESCRIPTION INFORMATION

❏ Written Below ❏ E-Prescribed ❏ Phoned In ❏ Faxed Separately | ❏ Compliance Packaging ❏ Spanish Instructions

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❏				
❏				
❏				
❏				

Dispense As Written (no stamps) **Date** **Substitution Permitted** (no stamps) **Date**

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.