

DATE: _____ CLINIC: _____

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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> MtF Female <input type="checkbox"/> FtM Male <input type="checkbox"/> Other:			
Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other:			Pronouns
Allergies		Current Medications	

IF INSURED	
Insurance Company	
BIN	PCN
Member ID	
Rx Group	
INSURED PATIENT CHECKLIST: <input type="checkbox"/> Complete "Patient Information" Section <input type="checkbox"/> Complete "If Insured" Section <input type="checkbox"/> Fax completed Avita PrEP Assistance Form <input type="checkbox"/> Fax both sides of the patient's insurance card	
NEXT STEPS: <input type="checkbox"/> Send Avita the prescription when ready <input type="checkbox"/> Avita will notify you and the patient with any updates and coordinate next steps.	

IF UNINSURED
Annual Household Income
Number of People in Household
Notes
UNINSURED PATIENT CHECKLIST: <input type="checkbox"/> Complete "Patient Information" Section <input type="checkbox"/> Complete "If Uninsured" Section <input type="checkbox"/> Fax completed Avita PrEP Assistance Form <input type="checkbox"/> Fax last two pay stubs OR last year's tax return <input type="checkbox"/> Fax Avita page 3 of the Gilead Advancing Access application with the prescriber's signature
NEXT STEPS: <input type="checkbox"/> Avita will complete the Gilead Advancing Access application on the patient's behalf. <input type="checkbox"/> Send Avita the prescription when ready <input type="checkbox"/> Avita will notify you and the patient with any updates and coordinate next steps.