Patient Enrollment

Select Location

avitapharmacy com

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 #
Patient Address			
Sex ❑ Male ❑ Female ❑ Intersex ❑ MtF Female ❑ FtM Male ❑ other:			
Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ other:			Pronouns
Allergies		340B Eligible ❑ Yes ❑ No	❑ HIV ❑ PrEP ❑ Other

PRESCRIBER INFORMATION

Prescriber Name	
Address	City, State, Zip
Office Contact	Phone

PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

INSURANCE

❑ Private Insurance ID#:	❑ Medicaid ID#:
❑ Medicare Part D ID#:	❑ Other: ID#:

PRESCRIPTION TRANSFER

Current Pharmacy Name	Phone Number
Prescription(s)	

Patient Enrollment

Select Location

PATIENT INFORMATION

Patient Name	Date of Birth
Patient Address	

PRESCRIBER INFORMATION

Prescriber Name	Entity/Organization	
Address	City, State, Zip	
Prescriber Type ❑ Physician (MD or DO) ❑ Nurse Practitioner ❑ Physician's Assistant	Supervising Physician (If prescriber is a NP or PA):	
Office Contact	Tel	Fax
DEA #	NPI #	

PRESCRIPTION INFORMATION

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

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
❑				
❑				
❑				
❑				
❑				