PrEP Assistance

Select Location

avitapharmacy.com

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 ❑ Male ❑ Female ❑ Intersex ❑ MtF Female ❑ FtM Male ❑ Other:			
Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ Other:			Pronouns
Allergies		Current Medications	

IF INSURED

Insurance Company	
BIN	PCN
Member ID	
Rx Group	

INSURED PATIENT CHECKLIST:

- ❑ Complete "Patient Information" Section
- ❑ Complete "If Insured" Section
- ❑ Fax completed Avita PrEP Assistance Form
- ❑ Fax both sides of the patient's insurance card

NEXT STEPS:

- ❑ Send Avita the prescription when ready
- ❑ 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:

- ❑ Complete "Patient Information" Section
- ❑ Complete "If Uninsured" Section
- ❑ Fax completed Avita PrEP Assistance Form
- ❑ Fax last two pay stubs OR last year's tax return
- ❑ Fax Avita pages 1 and 5 of the Gilead Advancing Access application with the prescriber and patient signatures.

NEXT STEPS:

- ❑ Avita will complete the Gilead Advancing Access application on the patient's behalf.
- ❑ Send Avita the prescription when ready
- ❑ Avita will notify you and the patient with any updates and coordinate next steps.