ElsaRx.org

FAX OR ESCRIPT ALL PRESCRIPTIONS TO:

ELSA PHARMACY INC
1802 East 4th Avenue, Hialeah, FL 33010
Phone: (305) 691-1968 Fax: (305) 836-2772
Email: Pharmacy@ElsaRx.Org

CLINIC NAME:	☐	340B Regular	☐	PREP	☐	T&T
TODAY'S DATE:	340B Eligible:		☐	Yes	☐	No

DELIVERY INFORMATION PCP:

Patient's Address:

Prescriber's Address:

Other Address:

CURRENT PHARMACY INFORMATION

Pharmacy: _____ Phone: _____ Fax: _____

Address: City, State, Zip:

PATIENT DEMOGRAPHICS (REQUIRED)

Last Name: First Name: Middle Name:

Preferred Name: Birth Date: _____ / _____ / _____ Pronouns:

Sex [Check One]: [ ] Male [ ] Female Gender Identity: [ ] Male [ ] Female [ ] Transgender [ ] Other

Street Address: P.O.Box City, State, Zip:

Phone Number: [ ] Home [ ] Cell Emergency Contact: Emergency Phone Number:

Please attach a copy of driver's license or photo ID front and back as well as Insurance Cards front and back (including prescription benefits)

Policy Insurance: Patient ID: Rx Group Number:

PCN: BIN: Subscriber's Name:

Patient Relationship to Subscriber [Check O [ ] Self [ ] Spouse [ ] Child [ ] Other: _____ ☐ Check to indicate front/back on Insurance card is attached.

PATIENT CLINICALS (REQUIRED) ***Please send additional sheet if neded for complete medication list***

Patient's Diagnosis [include IDC-10]:

Patient's Other Medical Conditions [include IDC-10]: □ No other medical conditions

Any known allergies or sensitivities: □ No known Allergies

Pertinent Medical History: □ No additional information

Is patient able to self-administer the medication prescribed? [ ] Yes [ ] No If "No" provide details:

PrEP: Date of last negative result: **HIV:** Current CD4 (T-Cell) count: **HIV:** Resistance test result:

HIV: Date of last positive result: **HIV:** Current viral load: **HCV:** Current viral load:

HCV: Genotype: **HCV:** IL-28B: **HCV:** Cliver Fibrosis:

Other Medications Including OTCs & Supplements	Dose, Route, Frequency	Diagnosis

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NEW PATIENT INFORMATION, NOTICE OF PRIVACY PRACTICES, THE PATIENT BILL OF RIGHTS, AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO

Patient/Guardian Signature: **Date:**

BY SIGNING BELOW, I AUTHORIZE ELSA PHARMACY INC TO CONTACT MY PRESENT PHARMACY AND TRANSFER ALL PRESCRIPTIONS TO BE FILLED.

Patient/Guardian Signature: **Date:**