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Compounding Pharmacy

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In-Office Use Only

General Patient Information (please print legibly)**:**

Name:___________________________ Address:_____________________________Apt. #:___________

City:_______________State: _______ Zip:___________ Phone:_________________ DOB:___________

Allergies to Medications: ____

Email:____

Insurance Information:

Carrier:____ RX BIN:_________________________

RX Group:____ PCN:__________________________________

ID Number:______________________________ Relation Code: (cardholder/spouse/dependent)

Information Required for Gilead Truvada® for PrEP Medication Assistance Program Activation:

- Are you a current resident of the United States, Puerto Rico, or US Territories?: Y N
- Are your prescriptions paid for in part or in full under any federally funded program, including but not limited to Medicare or Medicaid, VA, DOD, or TRICARE?: Y N
- Are you in Medicare Part D coverage gap (donut hole)?: Y N

*If you begin receiving prescription benefits from such state, federal, or government-funded program at any time, you will no longer be eligible to use Gilead Advancing Access Co-Pay coupon card.

Patient Signature:____ Date:_______________

Name:___________________________ DOB:____________________________ Date:________________

Address: ____

℞

Refill______________________Times

____
Prescriber's Signature

• Version 05.10.16