



# Treatment Enrollment Form

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Forms: [firstchoiceiv.com/infusion-services-forms/](http://firstchoiceiv.com/infusion-services-forms/)

## Patient Information

Patient Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ Gender: Male Female  
DOB: \_\_\_\_\_ Language Preference: English Spanish Other \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Emergency/guardian Contact: \_\_\_\_\_ Emergency/guardian Phone: \_\_\_\_\_

## Insurance Information

Please attach front and back of patient's insurance cards or complete the information below

Insurance Company: \_\_\_\_\_ Company Phone: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ ID#: \_\_\_\_\_ Group/Policy#: \_\_\_\_\_  
Prescription Card: Yes No Carrier: \_\_\_\_\_ Group/Policy#: \_\_\_\_\_  
Patient eligible for Medicare: Yes No Patient has secondary insurance: Yes No

## Prescriber Information

Prescriber's Name: \_\_\_\_\_ Hospital/Group: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Office Contact Person: \_\_\_\_\_  
NPI#: \_\_\_\_\_ DEA#: \_\_\_\_\_ State License#: \_\_\_\_\_

## Prior Authorization Information

- Patient demographic page
- Patient SSN
- Most recent H&P
- Most recent labs
- Copy of any/all insurance cards on file, both medical and pharmacy

Most Specialty Medications require insurance verification and Prior Authorization. At First Choice Wellness Centers, we do that work for you. Please send all the above documentation so we may quickly expedite these tasks for you without taking up your valuable time.

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**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Entyvio**

Infusion Order Form

**Clinical Information**

Primary ICD-10 Code: \_\_\_\_\_ Weight: \_\_\_\_\_ (kg /lbs ) Height: \_\_\_\_\_ (cm /in )

Patient previously treated for this condition: Yes No Patient currently on treatment: Yes No

Known Allergies: \_\_\_\_\_

All ICD-10 codes for any/all related diagnosis (if not listed in H&amp;P): \_\_\_\_\_

**Pre-medication Information**

Acetaminophen 325mg, can be repeated x1, not to exceed 650mg, PRN

Methylprednisolone 125mg IV, PRN

Diphenhydramine 25mg PO or IV, PRN

Ondansetron 4mg IV, PRN

**Medication Information**

Medication Note: PFS is abbreviation for Prefilled Syringes Directions/Frequency IV Access Type: Peripheral PICC Port

**Entyvio (vedolizumab)**

300mg IV at weeks 0, 2, and 6, then every 8 weeks

300mg IV every \_\_\_\_ weeks

Number of treatment months / refills: \_\_\_\_\_

**Laboratory Orders**

CBC Before each infusion Every: \_\_\_\_\_

CMP Before each infusion Every: \_\_\_\_\_

CRP Before each infusion Every: \_\_\_\_\_

Other: \_\_\_\_\_

**Notes**

In event of infusion reaction, follow Adverse Reaction Protocols for treatment.

Infusion reaction special orders: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

By signing below, I certify that the above therapy is medically necessary, and I authorize treatment.

Substitution allowed \_\_\_\_\_

Dispense as written \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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