First Choice
Wellness & Infusion Centers
Specialty Pharmacy

Treatment Enrollment Form

Toll Free Phone: 1-866-665-3244
Toll Free Fax: 1-844-461-3244
Email: infusions@firstchoiceiv.com
Forms: 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#: _____

Patient eligible for Medicare: ☐ Yes ☐ No Patient has secondary insurance: ☐ Yes ☐ No

Secondary Insurance Company: _____ Secondary Insurance ID: _____

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.

Revised: Jun 2022

Patient Information

Patient Name: _____ DOB: _____

IVIG

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&P): _____

Pre-medication Information

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

✓ **Diphenhydramine 25mg PO or IV, PRN**

☐ _____

✓ **Methylprednisolone 125mg IV, PRN**

✓ **Ondansetron 4mg IV, PRN**

☐ _____

Medication Information

Medication — Note: PFS is abbreviation for Prefilled Syringes

Directions/Frequency — IV Access Type: ☐ Peripheral ☐ PICC ☐ Port

IVIG Treatment – Initial

☐ _____ gm per day x _____ days every _____ weeks

☐ _____ gm/kg over x _____ days every _____ weeks

☐ _____ mg/kg over x _____ days every _____ weeks

IVIG Treatment – Maintenance

☐ _____ gm per day x _____ days every _____ weeks

☐ _____ gm/kg over x _____ days every _____ weeks

☐ _____ mg/kg over x _____ days every _____ weeks

☐ Do NOT round dose to nearest 5gm vial

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: _____

Revised: Jun 2022