



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#: _____
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.

Confidentiality Statement: The information contained in the following document(s) is legally privileged and confidential information intended only for the use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, you are hereby notified that any viewing, dissemination, distribution, or copy of the attached document(s) is strictly prohibited. If you have received and/or are viewing attached document(s) in error, please immediately notify the sender and arrange for the immediate return or destruction of the attached document(s).

Patient Information

Patient Name: _____ DOB: _____

Inflectra

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

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

Inflectra (infliximab-dyyb)

_____ mg/kg (weight-based) at weeks 0, 2, and 6, then every 8 weeks

_____ mg (flat-dose) at weeks 0, 2, and 6, then every 8 weeks

_____ mg/kg (weight-based) every _____ weeks

_____ mg (flat-dose) 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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