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#: _____

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.

Patient Information

Soliris – 18yo & up

Infusion Order Form

Patient Name: _____ DOB: _____

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**

☐ _____

Prescriber must indicate the following requirements have been met (must provide documentation)

☐ **Immunized patients with meningococcal vaccines at least two weeks prior to first dose**

OR

☐ **Provide 2 weeks of anti-bacterial of drug prophylaxis to patients if vaccines are administered less than 2 weeks before first dose**

Medication Information

Medication	Note: PFS is abbreviation for Prefilled Syringes	Directions/Frequency	IV Access Type: ☐ Peripheral ☐ PICC ☐ Port
Soliris (eculizumab)		**Number of treatment months / refills:** _____	
☐ Induction – 600mg weekly for first 4 weeks, 900mg dose on week 5, 900mg dose every 2 weeks thereafter			
☐ Induction – 900mg weekly for first 4 weeks, 1200mg dose on week 5, 1200mg dose every 2 weeks thereafter			
☐ Maintenance – 900mg every 2 weeks			
☐ Maintenance – 1200mg every 2 weeks			

Laboratory Orders

☐ **CBC** ☐ **Before each infusion** ☐ **Every:** _____

☐ **CMP** ☐ **Before each infusion** ☐ **Every:** _____

☐ **CRP** ☐ **Before each infusion** ☐ **Every:** _____

☐ **TB** ☐ **Before each infusion** ☐ **Every:** _____

Notes

✓ **Monitor patient for early signs of meningococcal infections**

✓ **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: _____