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

Uplizna

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): _____

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

☐ Quantitative immunoglobulins within normal limits

☐ Anti-aquaporin-4 (AQP4)antibody positive (required)

☐ Latent TB screening negative

☐ HBV screening negative

If any the above are not checked, attach treatment/consultation notes clearing patient for inebilizumab-cdon therapy

Pre-medication Information

✓ Acetaminophen 500mg to 650mg PO, once 30 minutes to 60 minutes prior to infusion

✓ Methylprednisolone 80mg to 125mg IV, once 30 minutes prior to infusion

✓ Diphenhydramine 25mg to 50mg PO, once 30 minutes to 60 minutes prior to infusion

Medication Information

Medication — Note: PFS is abbreviation for Prefilled Syringes

☐ **Uplizna (inebilizumab-cdon)**

Dilute **inebilizumab-cdon 300 mg/30 mL in 250 mL 0.9% sodium chloride** and administer intravenously using a sterile, in-line, low protein-binding **0.2- or 0.22-micron filter** using rates in table below.

Elapsed Time (minutes)	Infusion Rate
0-30	42mL/hr
31-60	125mL/hr
61 to completion	333mL/hr

✓ Flush with 0.9% sodium chloride at the completion of infusion

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

☐ On Day 1 and Day 15; repeat in 6 months (from Day 1)

☐ Every 6 months (date of last treatment: _____)

✓ **Pre-infusion**

✓ Assess for contraindications; hold infusion and notify provider for signs/symptoms of active infection, planned or recent invasive/surgical procedure, receipt of live or live-attenuated vaccines within 4weeks, chance of pregnancy, or signs/symptoms of PML (new or worsening unilateral weakness, confusion or changes in vision, thinking,memory, balance, or personality/mood).

✓ Obtain vital signs at baseline and with rate changes

✓ Establish vascular access

✓ If infusion-related reaction occurs, stop infusion and treat per orders/protocol as clinically indicated.

Notes

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

✓ **Monitor patient for hypersensitivity reaction for a period of 60 minutes following infusion.**

✓ Record vital signs immediately following infusionand prior to discharge.

✓ Leave IV in place for observation period; removeprior to discharge.

✓ Provide patient with discharge instructions.

☐ Fax treatment notes to provider at _____

☐ 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

Date: _____

_____ Dispense as written

Date: _____

Submit Form Electronically