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.

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Revised: Jun 2022

Patient Information

Patient Name: ______________________ DOB: __________

Vyvgart

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
Vyvgart (efgartigimod alfa-fcab) 10 mg/kg (For patients weighing less than 120kg), once per week for 4 weeks 1200mg (For patients weighing 120kg or more), once per week for 4 weeks Administer subsequent treatment cycles based clinical evaluation (see package insert).	**Number of treatment months / refills:** ______________

Laboratory Orders

CBC Before each infusion Every: ______________

CMP Before each infusion Every: ______________

CRP Before each infusion Every: ______________

Other: ______________________

Notes

Immunization with live-attenuated or live vaccines is not recommended during treatment.

Delay adminitration to patients with with an active infection.

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

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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