First Choice
Home Infusion
Specialty Pharmacy

Prescription & Enrollment Form

Toll Free Fax: 1-844-324-3244
Toll Free Phone: 1-866-665-3244
ePrescribe: NCPDP 4446654 / NPI 1366854788
Email: referrals@firstchoiceiv.com

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: _____

Alternate Phone: _____ Parent/guardian: _____

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: _____

Office Contact: _____ Street Address: _____

City, State, Zip: _____ Office Fax: _____

E-mail Address: _____ Office Phone: _____

NPI#: _____ DEA#: _____ State License#: _____

Prior Authorization Information

- ○ Patient demographic page
- ○ Most recent H&P
- ○ Most recent labs
- ○ Copy of any/all insurance cards on file, both medical and pharmacy

As you know, most Specialty Rx's require a PA and insurance verification, at First Choice Home Infusion we do that work for you. So that we may quickly expedite these tasks for you without taking up your valuable time, please initially send the above information.

Bleeding Disorder

Patient Contact Form

Patient Information

Patient Name: _____ DOB: _____ Weight: _____

Patient or Caregiver spoken to when obtaining this order: _____

Inquiry regarding current state of well-being: _____

Any bleed since last call: ☐ Yes ☐ No Site of bleed: _____ Is this a target joint: ☐ Yes ☐ No

Severity of bleed: ☐ Mild ☐ Moderate ☐ Severe If yes, enter intervention: ☐ MD consulted ☐ Patient education ☐ No intervention

For Prophylaxis regimen patients, have you missed any injections: ☐ Yes ☐ No If Yes, provide details: _____

Any upcoming Surgical, Dental, or Medical Procedures: _____

Additional Information

1) Adverse drug reactions:	☐ Yes ☐ No	2) Supply issues:	☐ Yes ☐ No	3) Storage questions or problems:	☐ Yes ☐ No
4) Change of address:	☐ Yes ☐ No	5) Change of insurance:	☐ Yes ☐ No	6) Change of medication:	☐ Yes ☐ No
7) Speak to a pharmacist:	☐ Yes ☐ No	8) Inhibitors:	☐ Yes ☐ No	8) Met goals of therapy:	☐ Yes ☐ No

For any questions answered Yes, please explain: _____

Prescription Information

Medication Note: PFS is abbreviation for Prefilled Syringes	Dose/Directions/Frequency	Qty	Refills

Supplies Information

Supply Item	Description	Qty	Refills

Notes

Shipping Information

Order Date: _____ Ship Date: _____ Delivery Date: _____

Shipping Address: _____ Shipping Attention To: _____

Shipping City: _____ Shipping State: _____ Shipping Zip Code: _____

Representative Signature: _____ Date: _____

Submit Form Electronically