



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

As you know, most Specialty Pharmacies require a Prior Authorization and insurance verification, at First Choice 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.

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: _____

**Crohn's Disease/
Ulcerative Colitis
Prescription Intake 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): _____

Prescription Information

Medication	Note: PFS is abbreviation for Prefilled Syringes	Dose/Directions/Frequency	Qty	Refills
Cimzia (certolizumab pegol) Starter Kit 6x200mg prefilled syringes 2x200mg Vials PFS				
Entyvio (vedolizumab) 300mg vial				
Humira (adalimumab) CD/UC/HS Starter Kit 6x40mg pens Pediatric Crohn's Starter Kit 3x40mg PFS Pediatric Crohn's Starter Kit 6x40mg PFS 40mg/0.8ml Pens PFS 20mg/0.4ml pediatric PFS				
Humira citrate free (adalimumab) Citrate Free CD/UC/HS Starter Kit 3x80mg/0.8ml Pens Citrate Free Pediatric Crohn's Starter Kit 3x80mg/0.8ml PFS Citrate Free Pediatric Crohn's Starter 1x80mg/0.8ml, 1x40mg/0.4ml PFS 40mg/0.4ml citrate free Pens PFS 20mg/0.2ml citrate free pediatric PFS				
Inflectra (infliximab-dyyb) 100mg vial				
Remicade (infliximab) 100mg vial				
Renflexis (infliximab-abda) 100mg vial				
Simponi (golimumab) 100mg SmartJect auto injector 100mg PFS Other: _____				
Stelara (ustekinumab) Induction: 130mg/26ml vial Maintenance: 90mg PFS Other: _____				
Xeljanz (tofacitinib) 5mg tablet				
Other				

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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