



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: _____

Hepatitis C

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
Epclusa (sofosbuvir / velpatasvir) Fixed-dose combination tablet of 400mg sofosbuvir / 100mg velpatasvir				
Harvoni (ledipasvir/ sofosbuvir) Fixed-dose combination tablet of 90mg ledipasvir / 400mg sofosbuvir				
Pegasys (peginterferon alfa-2a) 180mcg / 0.5mL ProClick™ Autoinjector				
Pegintron (peginterferon alfa-2b) 120mcg REDIPEN® 150mcg REDIPEN®				
Ribavirin 200mg Tablets Capsules				
Ribasphere RibaPak® (ribavirin) 600 / 600mg 600 / 400mg 400 / 400mg 200 / 400mg				
Sovaldi (sofosbuvir) 400mg tablets				
Technivie (ombitasvir/paritaprevir/ritonavir) Fixed dose combination tablet of ombitasvir / paritaprevir / ritonavir 12.5mg / 75mg / 50mg				
Vosevi (sofosbuvir, velpatasvir, and voxilaprevir) Fixed-dose combination tablet of 400mg sofosbuvir / 100mg velpatasvir/ 100mg voxilaprevir				
Zepatier (elbasvir/grazoprevir) Fixed dose combination tablet of 50mg elbasvir / 100mg grazoprevir				
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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