First Choice
Wellness & Infusion Centers
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 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.

Patient Information

Patient Name: _____ DOB: _____

IVIG

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
☐ **Gammagard** ☐ _____ grams / kg			
☐ **Gammaked** ☐ _____ grams / kg			
☐ **Gamunex-C** ☐ _____ grams / kg			
☐ **Hizentra** ☐ _____ grams / kg			
☐ **Octagam** ☐ _____ grams / kg			
☐ **Panzyga** ☐ _____ grams / kg			
☐ **Privigen** ☐ _____ grams / kg			
☐ **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: _____

Submit Form Electronically