



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.

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Patient Information

Patient Name: _____ DOB: _____

**Hematology Oncology
Infused Medication
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
Avastin (bevacizumab) _____ mg				
Dacogen (decitabine) _____ mg				
Darzalex (daratumumab) _____ mg				
Herceptin (trastuzumab) _____ mg				
Keytruda (pembrolizumab) _____ mg				
Kyprolis (carfilzomib) _____ mg				
Opdivo (nivolumab) _____ mg				
Perjeta (pertuzumab) _____ mg				
Rituxan (rituximab) _____ mg				
Velcade (bortezomib) _____ mg				
Yervoy (ipilimumab) _____ mg				
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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