



# 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: \_\_\_\_\_

### All Other Medications 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

### Prescriber Information

Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

By signing below, I certify that the above therapy is medically necessary, and I authorize treatment.

Substitution allowed \_\_\_\_\_

Date: \_\_\_\_\_

Dispense as written \_\_\_\_\_

Date: \_\_\_\_\_

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