First Choice
Wellness & Infusion Centers
Specialty Pharmacy

Treatment Enrollment Form

Toll Free Phone: 1-866-665-3244
Toll Free Fax: 1-844-461-3244
Email: infusions@firstchoiceiv.com
Forms: firstchoiceiv.com/infusion-services-forms/

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: _____

Emergency/guardian Contact: _____ Emergency/guardian Phone: _____

Insurance Information – Please attach front and back of patient's insurance cards

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: _____

Prescription Card: ☐ Yes ☐ No _____ ID#: _____

PCP Referral Required: ☐ Yes ☐ No PCP Name: _____

Prescriber Information

Prescriber's Name: _____ Hospital/Group: _____

Street Address: _____ Office Phone: _____

City, State, Zip: _____ Office Fax: _____

E-mail Address: _____ Office Contact Person: _____

NPI#: _____ Tax ID#: _____ State License#: _____

Prior Authorization Information – For us to complete PAs for you, please send the following:

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

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Revised: Apr 2023

Soliris – Under 18yo

Infusion Order Form

Patient Information

Patient Name: _____ DOB: _____

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): _____

Pre-medication Information

- ✔ **Acetaminophen 325mg, can be repeated x1, not to exceed 650mg, PRN**
- ✔ **Diphenhydramine 25mg PO or IV, PRN**
- ☐ _____
- ✔ **Methylprednisolone 125mg IV, PRN**
- ✔ **Ondansetron 4mg IV, PRN**
- ☐ _____

Prescriber must indicate the following requirements have been met (must provide documentation)

☐ **Immunized patients with meningococcal vaccines at least two weeks prior to first dose**

OR

☐ **Provide 2 weeks of anti-bacterial of drug prophylaxis to patients if vaccines are administered less than 2 weeks before first dose**

Medication Information

Medication — Note: PFS is abbreviation for Prefilled Syringes	Directions/Frequency — IV Access Type: ☐ Peripheral ☐ PICC ☐ Port
Soliris (eculizumab) – Under 18yo – Induction ☐ ____ mg weekly x ____ doses **Soliris (eculizumab) – Under 18yo – Maintenance** ☐ ____ mg at week ____ , then ____ mg every ____ weeks	**Number of treatment months / refills:** _____

Laboratory Orders

- ☐ **CBC** ☐ **Before each infusion** ☐ **Frequency:** _____
- ☐ **CMP** ☐ **Before each infusion** ☐ **Frequency:** _____
- ☐ **CRP** ☐ **Before each infusion** ☐ **Frequency:** _____
- ☐ **TB** **Every:** _____

Notes

- ✔ **Monitor patient for early signs of meningococcal infections**
- ✔ **In event of infusion reaction, follow Adverse Reaction Protocols for treatment.**
- ☐ **Infusion reaction special orders:** _____

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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