Prime Infusions

Phone: 718-443-4000
Fax: 718-443-5000

Sending a Referral to Prime Infusions

Follow the steps below to send a referral to Prime Infusions:

1. Download the desired order form from our website www.primeinfusions.com/referrals
2. Print and fill out all the fields.
3. Fax completed order form with all required documentation listed below to 718-443-5000.

Required Documentation Checklist

If we do not receive all documents below with your referral, the order is subject to delays.
**It may take up to 14 business days for the patient's insurance company to approve or deny our authorization request.*

- ☐ Completed Medication Order Form
- ☐ Patient Demographics
- ☐ Current Medication List and H&P
- ☐ Recent Visit Notes
- ☐ Lab Results
- ☐ Patient's Insurance Card
- ☐ Existing Prior Authorization (if applicable)

How to Use Our Digital Order Forms

Upon downloading the desired form, you will see light blue text box, check box, and circle box fields appear. To fill out the form on your computer, click into these fields to type out the necessary patient, office, clinical history, and therapy administration information. You can copy/paste information from the patient's medical record into this form.

Gather the referring provider's signature to approve the order once you have filled out all fields and send to Prime Infusions via fax at 718-443-5000.

Prescription Requirements

Please be advised that infusion order forms do not serve as valid prescriptions and may not be used as a substitute for one. In accordance with New York State law, a valid prescription must be transmitted electronically or faxed using an official New York State prescription format.

Orencia® Referral Form

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PATIENT INFORMATION **REFERRAL STATUS:** ☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB:_____ Patient Name: _____ Patient Phone_____

Patient Address: _____ Patient Email: _____

☐ NKDA Allergies: _____ Weight (lb/kg): _____ Height: _____

ICD-10 Code (required) _____ ICD-10 Code Description: _____Last Treatment Date:_____ Last 4 Digits SSN: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City, State, ZIP: _____

Physician Preferred Method of Contact ☐ Fax ☐ Phone ☐ Email:_____

NURSING

☐ Infusion to be administered per Prime Infusions protocols.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other _____

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐500mg ☐650mg ☐1000mg ☐PO ☐IV

☐ cetirizine (Zyrtec) 10mg ☐PO ☐IV

☐ loratadine (Claritin) 10mg ☐PO ☐IV

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐PO ☐IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg ☐PO ☐IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg ☐PO ☐IV

☐ Other _____

Dose: _____ Route: _____

ORENCIA® THERAPY ADMINISTRATION

INITIAL/RELOAD AND MAINTENANCE DOSING:
ADMINISTER AT 0, 2, AND 4 WEEKS, AND THEN EVERY 4 WEEKS

BODY WEIGHT OF PATIENT (DOSE)
LESS THAN 60 KG (500 MG)
60 TO 100 KG (750 MG)
MORE THAN 100 KG (1000 MG)

MAINTENANCE DOSE ONLY: ADMINISTER EVERY 4 WEEKS

BODY WEIGHT OF PATIENT DOSE
LESS THAN 60 KG (500 MG)
60 TO 100 KG (750 MG)
MORE THAN 100 KG (1000 MG)

OTHER:
ADMINISTER _____ MG
EVERY _____ WEEKS

REQUIRED DOCUMENTATION

☐ Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

☐ Hep B Surface Antigen (within 36 months)

TB Results (within 6 months)

Hep B Core

Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted*

PROVIDER NAME (PRINT) **PROVIDER SIGNATURE** **DATE**

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PHYSICIAN ORDER FORM IS VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE, UNLESS NOTED OTHERWISE.

1. **Orencia _____ mg every _____ days**
   a) (Dosing at _____ mg for patients weighing _____ kg to _____ kg)
   b) Patient's weight: _____ kg
2. **Reconstitution and administration:**
   a) Reconstitute each vial of Orencia with 10 mL of sterile water
   b) Dilute reconstituted Orencia (_____ mg) in a 100 mL bag of Normal Saline for a total volume of 100 mL
   c) Run infusion over 30 minutes using a sterile, low protein binding filter (size 0.2–1.2 micron), as tolerated
3. **Flush IV line with 0.9% Sodium Chloride 10 mL prefilled syringe pre/post infusion as needed**
4. **Anaphylaxis kit per protocol:**
   a) Epinephrine 0.3 mg autoinjector IM every 5 minutes x2 – call EMS
   b) Diphenhydramine 50 mg/mL (dispense 1 vial) – administer 50 mg IV during anaphylactic reaction
   c) Methylprednisolone 125 mg – administer IV push during anaphylactic reaction
   d) 0.9% Sodium Chloride 250 mL – administer during anaphylactic reaction
5. **Dispense pump and infusion supplies**
6. **Dispense _____ week supply**
   a) Refill (all above): _____
7. **Nursing orders and plan of treatment:**
   a) Nurse to place PIV or use PICC/PORT/CVC to infuse Orencia as directed
   b) Assess and monitor vital signs and systems review with each visit
   c) Instruct on the following:
      i) Disease progress, signs and symptoms, and complications
      ii) Medication therapy including action, purpose, side effects, and storage of medication and supplies
      iii) Universal precautions, 911, 24-hour phone number, and when to call RN or physician

PROVIDER INFORMATION

Referral Coordinator Name:: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City, State, ZIP: _____

Physician Preferred Method of Contact ☐ Fax ☐ Phone ☐ Email:_____

_____ _____

PROVIDER SIGNATURE DATE