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.

Rituxan® 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: _____

RITUXAN® THERAPY ADMINISTRATION

☐ Infuse Rituximab (Rituxan) OR Rituximab biosimilar/generic as required by patient's insurance.

☐ Do not use biosimilar/generic (subject to prior authorization).

Dose: ☐ 1000 mg ☐ 375 mg/m2 ☐ 500 mg

☐ Other: _____

FREQUENCY

☐ One time dose

☐ Day 0, repeat dose in 2 wks, then repeat course every _____ weeks OR _____ months x _____ months

☐ Day 0, repeat dose in 2 weeks

☐ Weekly x 4 weeks

☐ Every 6 months x _____ months

☐ Other _____

REQUIRED DOCUMENTATION

☐ Patient Demographics

☐ Insurance Card /Information

☐ Progress Notes Supporting DX

☐ Current Medication List and H&P

☐ Hep B Surface Antigen (within 36 months)

☐ Hep B Core (if available)

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**

Rituxan® Order Form

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

1. **Infuse Rituxan (_____mg/_____mL) _____mg IV for ___ doses, _____ days apart**
   a) For the first infusion, initiate at a rate of 50mg/hr. In the absence of an adverse reaction, increase the rate by 50mg/hr increments every 30 minutes to a maximum of 400mg/hr.
   b) For subsequent infusions, if tolerated, initiate infusion at a rate of 100mg/hr. In the absence of an adverse reaction, increase the rate by 100mg/hr increments at 30-minute intervals to a maximum of 400mg/hr
2. **Flush IV line with 0.9% Sodium Chloride 3mL prefilled syringe pre/post-Rituxan and as needed**
3. **Premedication:**
   a) Methylprednisolone 100mg IV, 30 minutes prior to Rituxan infusion
   b) Acetaminophen 325mg tablets – _____ tablets by mouth, 30 minutes prior to Rituxan infusion
   c) Diphenhydramine 25mg _____IV _____PO, 30 minutes prior to Rituxan infusion
4. **Anaphylaxis kit per protocol:**
   a) Epinephrine 0.3mg autoinjector IM every 5 minutes x2 – call EMS
   b) Diphenhydramine 50mg/mL (dispense 1 vial) – administer 50mg IV during anaphylactic reaction
   c) Methylprednisolone 125mg – administer IV push during anaphylactic reaction
   d) 0.9% Sodium Chloride 250mL – administer during anaphylactic reaction
5. **Dispense pump and infusion supplies**
6. **Nursing orders and plan of treatment:**
   a) Nurse to place PIV or use PICC/PORT/CVC to infuse Rituxan 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