



**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](http://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.

# Tepezza® Referral Form



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

## TEPEZZA® THERAPY ADMINISTRATION

☐ 10mg/kg for the initial dose

☐ 20mg/kg every three weeks for \_\_\_\_\_ additional infusions

## REQUIRED DOCUMENTATION

☐ Patient Demographics

☐ Insurance Card/Information

☐ Progress Notes Supporting DX

☐ Current Medication List and H&P

☐ Free T3 and Free T4

☐ Clinical Activity Score (CAS)

☐ Thyroid Panel with TSH

☐ HbA1C (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

# Tepezza® Order Form



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

## 1. Infuse:

- a) Infuse Tepezza \_\_\_\_\_ mg IV for the initial dose
- b) Infuse Tepezza \_\_\_\_\_ mg IV for the following \_\_\_\_\_ infusions

## 2. Run the first two infusions over 90 minutes. Future infusions may be reduced to 60 minutes if tolerated.

## 3. Flush IV line with 0.9% Sodium Chloride 3mL prefilled syringe pre/post infusion as needed

## 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 Tepezza 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