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.

BRIUMVI® Referral Form

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

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: . ☐ SEE LIST ☐ NKDA WEIGHT: _____ ☐ LB ☐ KG

REQUIRED DOCUMENTATION

☐ Insurance Card ☐ History & Physical ☐ Patient Demographics ☐ Most Recent Labs

☐ Medication List ☐ MRI Results ☐ Neg Hep B Serology ☐ Immunoglobulin Panel

PRIMARY DIAGNOSIS

☐ G35 Multiple Sclerosis ☐ Other _____

LAB ORDERS

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☐ Per infusion clinic protocol: Acetaminophen 650 mg PO, Diphenhydramine 25 mg IV, and Methylprednisolone 100 mg IV (30 minutes prior to start of infusion)

☐ Provider Prescribed: _____

PRIMARY MEDICATION

☐ Induction: Briumvi 150 mg IV on day 1, followed by 450 mg on day 15, then 450 mg IV every 6 months thereafter.

☐ Maintenance: Briumvi 450 mg IV every 6 months

☐ Other _____

FIRST DOSE?: ☐ YES ☐ NO ☐ Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

☐ Start PIV/ACCESS CVC

☐ Flush device per Prime Infusions Protocol

☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☐ Administer acute infusion and anaphylaxis medications per Prime Infusions protocol

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE #: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

_____ _____

PROVIDER SIGNATURE DATE

BRIUMVI® Infusion Order Form

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

1. **Start Briumvi 150mg IV on day 1 and 450mg IV on day 15**
2. **For the first infusion of 150mg infuse medication over 4 hours. Start at 10 mL per hour for the first 30 minutes then**
   a) increase to 20 mL per hour for the next 30 minutes then increase to 35 mL per hour for the next hour and then increase to 100 mL per hour for the remaining 2 hours or as tolerated.
   b) For the second infusion of 450 mg on day 15 infuses patients over 1 hour. Start at 100 mL per hour for the first 30 minutes and then increase to 400 mL per hour for the remaining 30 minutes
   c) Monitor patients closely during and for at least one hour after the completion of the first two infusions.
3. **Flush**
   a) Flush IV line with 0.9% Sodium chloride 3mL prefilled syringe pre/post infusion as needed
4. **Premedication**
   a) Acetaminophen 1000mg PO 30-60 minutes prior to infusion
   b) Hydrocortisone 100mg IVP or Methylprednisolone 125mg IVP 30-60 minutes prior to infusion
   c) Cetirizine 10mg PO 30-60 minutes prior to infusion
5. **Anaphylaxis Kit Per Protocol**
   a) Epinephrine 0.3mg Autoinjector IM per protocol every 5 minutes x 2- 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
6. **Dispense Pump and Infusion Supplies**
7. **Nursing Orders and Plan of Treatment**
   a) Nurse to place PIV or use PICC/PORT/CVC to infuse Briumvi 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 complication
      ii) Medication therapy including action, purpose, side effects, storage of medication and supplies
      iii) Universal precautions, 911, 24 hour phone number, when to call RN/Physician

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE #: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

_____ _____

PROVIDER SIGNATURE DATE