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.
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

1. 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.
2. There is a section at the bottom of each fillable form that allows "Additional Notes from Referring Office" to be added. If you are not finding a field to enter information you need to send over, please put it here.
3. Gather the referring provider's signature to approve the order once you have filled out all fields and send to Prime Infusions via fax.

PEMGARDA® Referral Form

Prime Infusions
Phone: 718-443-4000
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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:_____

CLINICAL HISTORY

Pemgarda is used under EUA for the pre-exposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents (12 years of age and older weighing at least 40 kg).

Criteria for use under the EUA:

☐ Not currently infected with SARS-CoV-2 and who have not had known recent exposure.

AND

☐ Moderate-to-severe immune compromised due to a medical condition or receiving immunosuppressive medications or treatments and are unlikely to mount an adequate immune response to COVID-19 vaccination.

PEMGARDA (PEMIVIBART) IV ADMINISTRATION

Dose: 4500mg

Frequency: ☐ Once ☐ Repeat every 3 months

Number of Doses: _____

Date of last infusion if not at PI: _____
RX Expiration Date: _____

REQUIRED DOCUMENTATION

☐ Patient Demographics

☐ Insurance Card/Information

☐ Progress Notes Supporting DX

☐ Current Medication List and H&P

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**