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.

STELARA® 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.
☐ TB status & date (list results here & attach clinicals)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other _____

PREMEDICATIONS

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

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

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

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

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other _____

Dose: _____ Route: _____

REQUIRED DOCUMENTATION

☐ Patient Demographics

☐ Insurance Card/Information

☐ Progress Notes Supporting DX

☐ Current Medication List and H&P

☐ TB Results within 12 months

STELARA THERAPY ADMINISTRATION

☐ **Stelara in 250ml 0.9% sodium chloride, intravenous infusion, use in line filter 0.2 micron**
- Dose: ☐ 260mg (2 vials) / ☐ 390mg (3 vials) / ☐ 520mg (4 vials)
- Frequency: single intravenous infusion (week 0)
- Route: intravenous
- Infuse over at least 60 minutes
- Flush with 0.9% sodium chloride at infusion completion

☐ **Stelara one-time intravenous infusion followed by subcutaneous dose 8 weeks later**
- Dose: ☐ 260mg (2 vials) / ☐390mg (3 vials) / ☐ 520mg (4 vials)
- Frequency: single intravenous infusion (week 0)
- Route: intravenous
- Infuse over at least 60 minutes
- Flush with 0.9% sodium chloride at infusion completion
- SC Dose: ☐ 90mg
- Frequency: subcutaneous dose at week 8 after week 0 intravenous dose and every 8 weeks thereafter
- Route: subcutaneous

☐ **Subcutaneous Stelara**
- Dose: ☐ 0.75mg/kg / ☐ 45mg / ☐ 90mg
- Frequency: ☐ induction: week 0 and 4, then every 12 weeks / maintenance: every 12 weeks / ☐ other: [redacted]
- Route: subcutaneous

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ [redacted]
(if not indicated order will expire one year from date signed)

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 _____

STELARA® Order Form

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

1. **Dosing Information:**
   a) Loading dose: Infuse Stelara _____ mg IV in 250 mL Normal Saline over 60 minutes with a micron filter
   b) Maintenance dose: Inject Stelara 90 mg subcutaneous injection every ___ weeks
2. **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
3. **Dispense injection supplies**
4. **Nursing orders and plan of treatment:**
   a) Nurse to inject subcutaneous Stelara 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