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.

Infliximab (Remicade, Renflexis, Avsola) 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:_____

CLINICAL HISTORY

In the past year, what medications for the above diagnosis has the patient tried and failed?

1. Drug/Dose/Date of Use _____/_____/_____
2. Drug/Dose/Date of Use _____/_____/_____
3. Drug/Dose/Date of Use _____/_____/_____

TB Verification (check one):
☐ Skin Test ☐Spot/Quantiferon Blood Test ☐ Chest X-Ray

Result Date: _____

Result (check one): ☐ Positive ☐ Negative

NURSING

☐ Infusion to be administered per Prime Infusions protocols.

LABORATORY ORDERS

☐ BMP ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CBC w/ Diff ☐ at each dose ☐ every _____
☐ CBC w/o Diff ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ ESR ☐ at each dose ☐ every _____
☐ Hepatic Panel ☐ at each dose ☐ every _____
☐ Other _____

PREMEDICATIONS

☐ Diphenhydramine ☐ PO or ☐ IV ☐ 25mg or ☐ 50mg
OR ☐ Cetirizine ☐ 10 mg PO

☐ Acetaminophen PO _____ mg

☐ Hydrocortisone IV Push _____ mg
OR ☐ Methylprednisolone IV Push _____ mg

THERAPY ADMINISTRATION

1) ☐ PI provider to select product (chosen based on patient's insurance coverage and availability).
2) ☐ Select a product from the list below:
(depending on the patient's health plan, choosing a specific drug may necessitate additional communication and the need for us to recommend an alternative infliximab).

☐Renflexis ☐Infliximab ☐Avsola ☐Inflectra

Dose: ☐ 3 mg/kg ☐ 5 mg/kg ☐ 7.5 mg/kg ☐ 10 mg/kg
☐_____ mg/kg ☐ _____ mg

Frequency: ☐ Initial Dose – 0, 2, 6 weeks,
THEN ☐ q6 weeks ☐ q8 weeks ☐ q ____ weeks
*If dosing ordered other than indicated by package insert, please provide a letter of medical necessity.

When calculating dose, round to nearest:
☐ vial (100mg per vial) ☐ half vial (50mg increment)

Date of last infusion if not at PI: _____ RX Exp.:_____

REQUIRED DOCUMENTATION

☐ 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)

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**

Infliximab (Remicade, Renflexis, Avsola) Order Form

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

1. **Infuse Infliximab _____mg IV at week 0, 2 and 6**
2. **For initial infusion or if patient has had a reaction in the past, start at 10ml/hr and double the rate every 15 minutes. Wait 30 minutes before increasing from 150 ml/hr to 250ml/hr. Run subsequent infusions for at least 2 hours at 125mL/hr with an in-line filter. If the patient has reacted to past use, titration protocol applies.**
3. **Flush**
   a) IV line with 0.9% Sodium Chloride 3mL prefilled syringe pre/post infusion as needed
4. **Premedication only if specified by prescriber**
   a) Diphenhydramine 25mg capsules – take _____ capsules 15–30 minutes prior to Infliximab infusion
   b) Acetaminophen 325mg tablets – take _____ tablets by mouth prior to Infliximab infusion
5. **Anaphylaxis kit per protocol**
   a) Epinephrine 0.3mg autoinjector IM per protocol 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
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 Infliximab 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, storage of medication and supplies

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