PRIMERA SPECIALTY
INFUSION

WELLNESS THERAPY REFFERAL

PHONE:(689)303-3338
FAX:(689)303-3240

Patient Name _____
Date of Birth _____
Gender at Birth ◯ Male ◯ Female
Address _____
City, State, Zip _____
Phone _____
Email _____
Primary Insurance _____
Secondary Insurance _____

Prescriber Name _____
NPI # _____ DEA # _____
State Lic # _____ UPI # _____
Practice Name _____
Address _____
City, State, Zip _____
Office Contact _____
Office Contact Phone _____
Office Contact Email _____

CLINICAL INFORMATION CHECKLIST

- ☐ Driver's License
- ☐ Insurance Cards (Front & Back)
- ☐ Most Recent Chart Note
- ☐ Most Recent Hospital Note
- ☐ Most Recent Labs & Imaging
- ☐ Other Relevant Clinical Data

PRESCRIPTION INFORMATION

Medication	☐ Hydration IV ☐ B12 SQ ☐ BPC-157 /TB-500 /GHK-Cu SubQ ☐ RED by Elevare ☐ Myer's Cocktail IV ☐ Tirzepatide SQ ☐ CJC-1295 / Ipamorelin SubQ ☐ Massage Chair ☐ NAD + IV ☐ Dihexa PO ☐ NAD+ SubQ
Directions	☐ Per Primera Specialty Infusion Protocol
Anaphylaxis Orders and Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol Diphenhydramine 50mg/mL slow IVP/IM Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg) Administer 50mg (wt. > 30kg) Qty 1 Epinephrine 1mg/mL– Administer___ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM Qty: 2 Sodium Chloride 0.9% – Administer 250mL IV at KVO (20ml/hr)
Flushing Protocol	☐ Sodium Chloride 0.9% 5-10mL pre and post medications
Pump & Ancillary Supplies	☐ Pump and supplies as needed for administration and appropriate disposal of infusion materials
Skilled Nursing Visits	☐ As needed for IV access, administration and appropriate clinical monitoring

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution.

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge.

I authorize Primera Specialty Infusion to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Primera Specialty Infusion.

Phone (689) 303-3338 Fax (689) 303-3240 Mail 795 Primera Blvd, Ste 1011, Lake Mary, FL 32746

Prescriber Signature _____ Date _____