Phone: 732-390-7750 Fax: 844-683-2244 ***AsteraCancerCare.org***

PATIENT REFERRAL FORM *GASTROENTEROLOGY*

Patient Name: _____ Pt. DOB: _____/_____/_____
Last First Middle

Patient Address: _____

Patient City: _____ Pt. State: _____ Pt. Zip: _____

Patient Phone: (____) _____-_____ Pt. Height: _____ in.

DX: _____ Pt. Weight: _____ lbs.

Patient Allergies: _____

Insurance: _____ ID#: _____

Referred by: _____ NPI#: _____

Office Contact (Required): _____ Office Ph: (___) _____-_____

Office Fax: (___) _____-_____

Office Administrator (Required): _____ Administrator Ph: (___) _____-_____

Astera Infusion Therapy scheduling location request:

☐Bridgewater ☐East Brunswick ☐Edison ☐Jersey City ☐Monroe ☐Robbinsville ☐Rutherford ☐Somerset

Required Items/Infusion Process:

☐ **Valid/signed prescription including name of medication, exact dosage, and directions**
(prescription only valid for 6 months, including refills)

☐ Copy of current insurance card

☐ Recent MD consultation notes: relevant disease being treated must be mentioned in report

☐ Allergies and current medication list

☐ Current labs required for specific medication, as noted on the following page(s) of this form

Has the patient initiated treatment at your office? ☐ Yes ☐ No

☐ If any future lab tests are needed, please provide patient with a prescription, and have patient bring on day of treatment. Results will be sent to referring physician.

Please note:

1. A Letter of Medical Necessity is required for all patients receiving their initial infusion at Astera (letter must include diagnosis, previous treatments/response to treatments and be on letterhead with physician signature).
2. ***Benefit investigations, copay assistance and prior authorizations will be handled by the Astera precert staff if required by the payer. Right to auto-substitute biosimilars based on payer's preference.*** Detailed clinical notes providing supportive documentation are required for authorization requests which may take 3-5 business days depending on the payer. The precert staff will update the referring doctor's office during this process and contact the patient to discuss cost and financial assistance options.
3. A pretreatment education session will be provided by an Advanced Practice Provider.
4. Once the infusion is complete, a follow-up notice will be faxed to the to the referring provider.

Patient Name: _____ DOB: _____/_____/_____
Last First Middle

Please check the box for medication requested, attach required documentation as noted below, and fax all documents to our office at 844.683.2244. Once all documentation is received, we will contact your patient to schedule an appointment. Thank you!

Medication	Required Current Lab Results

Note: Progress notes and labs must be completed within the previous 6 months for all new and renewed prescriptions.

- ☐ Cimzia — CBC, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- ☐ Entyvio — Liver Function, PPD (prior to initiation)
- ☐ Evenity — CMP, Dexa Scan within 2 years
  - ☐ Confirm pt. has not had an MI or stroke within previous year
- ☐ Remicade/Inflectra (Biosimilar might be replaced if appropriate) — CBC, Liver Function, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- ☐ Simponi Aria (IV) — CBC, Liver Function, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- ☐ Skyrizi (IV) — Crohn's Disease Indication only - CBC, CMP (with LFTs), Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
  - ☐ Confirm No Vaccinations within 4 Weeks of Therapy or have an active infection
- ☐ Stelara (IV) — CBC, PPD
- ☐ Tysabri — MRI (MS patients), TOUCH Program Registration