



Phone: 732-390-7750 Fax: 844-683-2244

AsteraCancerCare.org

PATIENT REFERRAL FORM

NEUROLOGY

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

Patient Address:

Patient City: Pt. State: Pt. Zip:

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

ICD-10 Code(s): Pt. Weight: lbs.

Patient Allergies:

Insurance: ID#:

Referred by: NPI#:

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

Office Fax: () -

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

Astera Infusion Services scheduling location request: Brick Bridgewater East Brunswick Edison Jersey City Monroe Robbinsville Rutherford Somerset Toms River

Required Items/Infusion Process:

Valid/signed written 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...
2. Benefit investigations, copay assistance and prior authorizations will be handled by the Astera precert staff...
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 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.

- Briumvi CBC, Quantitative Serum Immunoglobulin, Prior to initiation – Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
 - Confirm No Vaccinations within 4 Weeks of Therapy
- Evenity CMP, DEXA Scan within 2 years
 - Confirm pt. has not had an MI or stroke within previous year
- IVIG Hematocrit, Hemoglobin, IgG Concentrations, Platelets, Renal Function Tests, Urine Output
Provide dose basis in mg/kg. Doses will be rounded to the nearest vial size available.
- Kisunla CMS Registry Number. Prior to initiation – confirm presence of amyloid beta pathology and brain MRI. Obtain an MRI prior to the 2nd, 3rd, 4th, and 7th infusions.
- Leqembi CMS Registry Number. Prior to initiation – confirm presence of amyloid beta pathology and brain MRI. Obtain an MRI prior to the 3rd, 5th, 7th and 14th infusions.
- Ocrevus CBC, prior to initiation - Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
 - Confirm No Vaccinations within 4 Weeks of Therapy
- Radicava None
- Rituxan/Riabni/Truxima/Ruxience (CMS approved indications only - Biosimilar might be replaced if appropriate)
CBC, prior to initiation - Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
 - Confirm No Vaccinations within 4 Weeks of Therapy
- Soliris Meningococcal Vaccination
- Tysabri MRI (MS patients), TOUCH Program Registration
- Vyepi None
- Vyvgart Anti-AChR Antibody Positive, No Live Vaccines During Therapy
- Vyvgart Hytrulo (SQ – CIDP and Myasthenia Gravis)
Anti-AChR Antibody Positive (Myasthenia Gravis only). No live vaccines during therapy.
Confirm no active infection.