



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

AsteraCancerCare.org

PATIENT REFERRAL FORM

RHEUMATOLOGY

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

Patient Address:

Patient City: Pt. State: Pt. Zip:

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

- 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).
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.
A pretreatment education session will be provided by an Advanced Practice Provider.
Once the infusion is complete, a follow-up notice will be faxed to the to the referring provider.

Patient Name: _____
Last First Middle

DOB: ____/____/____

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.

- Actemra CBC, Lipid Panel, Liver Function, PPD (prior to initiation)
- Benlysta(IV) None
- Cimzia CBC, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- Evenity CMP, DEXA Scan within 2 years
 - Confirm pt. has not had an MI or stroke within previous year
- Krystexxa G6PD Deficiency, Serum Uric Acid Levels, Confirm Oral Urate Lowering Agent Discontinued
- Orencia(IV) Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- 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)
- Rituxan 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
- Saphnelo Up to date with all immunizations before treatment initiation and confirm no live or live attenuated vaccines are given concurrently.
- 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)
- Stelara(IV) CBC, PPD
- Vpriv Gene Testing (GBA – Velaglucerase Alfa)