



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

SpecializedInfusionTherapy.com

PATIENT REFERRAL FORM

GENERAL

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: () -

Astera Infusion Therapy scheduling location request:

- East Brunswick Edison Monroe Robbinsville Rutherford Somerset Somerville

Required Items/Infusion Process:

- Valid/signed prescription including name of medication, exact dosage, and directions (prescription only valid for 12 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

Please note:

- A Letter of Medical Necessity may be required. If required, you will be contacted by Astera Infusion Therapy (letter must include diagnosis, previous 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. 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 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 844.683.2244. Once all documentation is received, we will contact your patient to schedule appointment. Thanks!

- | <u>Medication</u> | <u>Required Current Lab Results</u> | <i>Note: All Labs Must be Completed Within the Previous 6 Months</i> |
|------------------------------------|--|--|
| <input type="checkbox"/> Actemra | CBC, Lipid Panel, Liver Function, PPD | |
| <input type="checkbox"/> Benlysta | None | |
| <input type="checkbox"/> Boniva | CMP, DEXA Scan within 2 years | <input type="checkbox"/> Confirm patient is in good dental health and has no outstanding dental issues |
| <input type="checkbox"/> Cimzia | CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), PPD | |
| <input type="checkbox"/> Cinqair | Peak Flow and Other Pulmonary Function Tests | |
| <input type="checkbox"/> Cytosan | CBC, CMP, UA | |
| <input type="checkbox"/> Entyvio | Liver Function, PPD | |
| <input type="checkbox"/> Evenity | CMP, DEXA Scan within 2 years | <input type="checkbox"/> Confirm pt. has not had an MI or stroke within previous year |
| <input type="checkbox"/> Fasenra | Peak Flow and Other Pulmonary Function Tests | |
| <input type="checkbox"/> Inflectra | CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), Liver Function, PPD | |
| <input type="checkbox"/> IV Iron* | Reticulocyte Count, Serum Iron, TIBC, Transferrin Saturation | *Feraheme, Ferrlecit, Infed, Injectafer, Venofer |
| <input type="checkbox"/> IVIG | Hematocrit, Hemoglobin, IgG Concentrations, Platelets, Renal Function Tests, Urine Output | |
| <input type="checkbox"/> Krystexxa | G6PD Deficiency, Serum Uric Acid Levels, Confirm Oral Urate Lowering Agent Discontinued | |
| <input type="checkbox"/> Nucala | FEV1, Peak Flow and Other Pulmonary Function Tests | |
| <input type="checkbox"/> Nulojix | CBC, EBV Serology, Magnesium, Operative Report, Potassium, PPD | |
| <input type="checkbox"/> Ocrevus | CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody) | <input type="checkbox"/> Confirm No Vaccinations within 4 Weeks of Therapy |
| <input type="checkbox"/> Orencia | Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), PPD | |
| <input type="checkbox"/> Prolastin | Alpha 1 Proteinase Inhibitor Serum Levels and Lung Function | <input type="checkbox"/> IgA antibodies negative for patient with IgA deficiency |
| <input type="checkbox"/> Prolia | CMP, DEXA Scan within 2 years | <input type="checkbox"/> Confirm patient is in good dental health and has no outstanding dental issues |
| <input type="checkbox"/> Provenge | PSA Level | |
| <input type="checkbox"/> Radicava | None | |
| <input type="checkbox"/> Reclast | CMP, DEXA Scan within 2 years | <input type="checkbox"/> Confirm patient is in good dental health and has no outstanding dental issues |

- Remicade CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), Liver Function, PPD
- Rituxan CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
 - Confirm No Vaccinations within 4 Weeks of Therapy
- Simponi Aria CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), Liver Function, PPD
- Soliris Meningococcal Vaccination
- Stelara CBC, PPD
- Tepezza Confirm pt. with preexisting diabetes is under appropriate glyceic control
- Tysabri MRI (MS patients), TOUCH Program Registration
- Uplinza Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody) and TB screening
- Vyepti None
- Xolair Baseline Serum Ige, FEV1, Peak Flow, Other Pulm Function Test (all required for asthma indication only)