



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

SpecializedInfusionTherapy.com

PATIENT REFERRAL FORM

Neurology

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

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: ( ) -

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: \_\_\_\_\_ 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: All Labs Must be Completed Within the Previous 6 Months*

- Boniva CMP, DEXA Scan within 2 years  
 Confirm patient is in good dental health and has no outstanding dental issues
- Cimzia CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), PPD
- Evenity CMP, DEXA Scan within 2 years  
 Confirm pt. has not had an MI or stroke within previous year
- Inflectra CBC, Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), Liver Function, PPD
- IV Iron\* Reticulocyte Count, Serum Iron, TIBC, Transferrin Saturation  
\*Feraheme, Ferrlecit, Infed, Injectafer, Venofer
- IVIG Hematocrit, Hemoglobin, IgG Concentrations, Platelets, Renal Function Tests, Urine Output
- Nulojix CBC, EBV Serology, Magnesium, Operative Report, Potassium, PPD
- Ocrevus 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
- Prolia CMP, DEXA Scan within 2 years  
 Confirm patient is in good dental health and has no outstanding dental issues
- Radicava None
- Reclast CMP, DEXA Scan within 2 years  
 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
- Stelara CBC, PPD
- Tysabri MRI (MS patients), TOUCH Program Registration
- Uplizna Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody) and TB screening
- Vyepiti None