



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 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 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 to the referring provider.

