



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

**AsteraCancerCare.org**

**PATIENT REFERRAL FORM**

**GENERAL**

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

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: ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

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 (letter must include diagnosis, previous treatments/response to treatments and be on letterhead with physician signature).
2. **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 and receipt of complete documentation from the referring office. The precert staff will update the referring doctor's office during this process and contact the patient to discuss cost and financial assistance options. For certain medications, patients will be required to register/enroll with the pharmaceutical company prior to rendered services and will receive a call from an Astera Financial Counselor to assist with this process.
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 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!**

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
- ☐ 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
- ☐ Cimzia      CBC, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- ☐ Cytoxan      CBC, CMP, UA
- ☐ Entyvio      Liver Function, PPD (prior to initiation)
- ☐ Evenity      CMP, Dexa Scan within 2 years      ☐ Confirm pt. has not had an MI or stroke within previous year
- ☐ Fasenra      Peak Flow and Other Pulmonary Function Tests
- ☐ Ilumya      CBC, CMP, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
  - ☐ Confirm up to date with vaccines and no live vaccinations within 4 weeks prior to starting therapy or have an active infection. Evaluated for malignancy.
- ☐ 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.
- ☐ Krystexxa      G6PD Deficiency, Serum Uric Acid Levels, Confirm Oral Urate Lowering Agent Discontinued
- ☐ Leqembi      CMS Registry Number. Prior to initiation – confirm presence of amyloid beta pathology and brain MRI.  
Obtain an MRI prior to the 5<sup>th</sup>, 7<sup>th</sup> and 14<sup>th</sup> infusions.
- ☐ Leqvio      Lipid Panel
- ☐ Nucala      FEV1, Peak Flow and Other Pulmonary Function Tests
- ☐ 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

- ☐ Orencia (IV) Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- ☐ Radicava None
- ☐ 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/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
- ☐ 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)
- ☐ Skyrizi (IV) Crohn's Disease Indication only - CBC, CMP (with LFTs), Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)  
☐ Confirm No Vaccinations within 4 Weeks of Therapy or have an active infection
- ☐ Soliris Meningococcal Vaccination
- ☐ Tezspire FEV1, Peak Flow and Other Pulmonary Function Tests
- ☐ Tysabri MRI (MS patients), TOUCH Program Registration
- ☐ Vpriv Gene Testing (GBA – Velaglycerase Alfa)
- ☐ Vyepti 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.
- ☐ Xolair Asthma - Baseline Serum IgE, FEV1, Peak Flow, Other Pulmonary Function Test  
Chronic Idiopathic Urticaria – None