Phone: 732-390-7750 Fax: 844-683-2244 ***SpecializedInfusionTherapy.com***

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 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:

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. The precert staff will update the referring doctor's office during this process and contact the patient to discuss cost and financial assistance options.
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: _____ DOB: _____/_____/_____
Last *First* *Middle*

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

☐ Cimzia CBC, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)

☐ Cinqair Peak Flow and Other Pulmonary Function Tests

☐ 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

☐ 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.

☐ Krystexxa G6PD Deficiency, Serum Uric Acid Levels, Confirm Oral Urate Lowering Agent Discontinued

☐ Nucala FEV1, Peak Flow and Other Pulmonary Function Tests

☐ Nulojix CBC, EBV Serology, Magnesium, Operative Report, Potassium, PPD (prior to initiation)

☐ 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)

☐ Prolastin Alpha 1 Proteinase Inhibitor Serum Levels and Lung Function
☐ IgA antibodies negative for patient with IgA deficiency

☐ 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 (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

- ☐ 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)
- ☐ Soliris Meningococcal Vaccination
- ☐ Stelara(IV) CBC, PPD
- ☐ Tysabri MRI (MS patients), TOUCH Program Registration
- ☐ Vyepti None
- ☐ Vyvgart CBC, Anti-AChR Antibody Positive, No Live Vaccines During Therapy
- ☐ Xolair Baseline Serum Ige, FEV1, Peak Flow, Other Pulm Function Test (all required for asthma indication only)