



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

SpecializedInfusionTherapy.com

PATIENT REFERRAL FORM

GASTROENTEROLOGY

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: () -

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 12 months, including refills) (if no refills specified, will honor 6 months) 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 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).
- 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.
- 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.

Patient Name: _____
Last First Middle

DOB: ____/____/____

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, Hepatitis B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), PPD

- Entyvio Liver Function, PPD

- Evenity CMP, DEXA Scan within 2 years
 Confirm pt. has not had an MI or stroke within previous year

- IV Iron* Reticulocyte Count, Serum Iron, TIBC, Transferrin Saturation
*Feraheme, Ferrlecit, Infed, Injectafer, Venofer

- Prolia CMP, DEXA Scan within 2 years
 Confirm patient is in good dental health and has no outstanding dental issues

- Reclast CMP, DEXA Scan within 2 years
 Confirm patient is in good dental health and has no outstanding dental issues

- Remicade/Inflectra (Biosimilar might be replaced if appropriate)
CBC, Hepatitis B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), Liver Function, PPD

- Simponi Aria(IV) CBC, Hepatitis B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody), Liver Function, PPD

- Stelara(IV) CBC, PPD

- Tysabri MRI (MS patients), TOUCH Program Registration