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

PATIENT REFERRAL FORM *UROLOGY*

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 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:

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 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
☐ 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
☐ Nulojix	CBC, EBV Serology, Magnesium, Operative Report, Potassium, PPD
☐ 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