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

SpecializedInfusionTherapy.com

PATIENT REFERRAL FORM

Patient Name: ____ Pt. DOB: _____/_____/_____
Last *First* *Middle*

Patient Address: ____

Patient City: _______________________________ Pt. State: ___________ Pt. Zip: ___________

Patient Phone: (____) _______-____________________ Pt. Height: __________ in.

DX: ____ Pt. Weight: __________ lbs.

Insurance: _______________________________________ ID#: __________________

Referred by: ______________________________________ NPI#: _________________

Office Contact (Required): _____________________________ Office Ph: (___) ______-__________
Office Fax: (___) ______-__________

RCCA CJD scheduling location request:
☐ East Brunswick ☐ Edison ☐ Monroe ☐ Somerset ☐ Somerville

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 page 2 of this form

Has the patient initiated treatment at your office? ☐ Yes ☐ No

Please note:
1. A Letter of Medical Necessity may be required. If required, you will be contacted by RCCA CJD (letter must include diagnosis, previous treatments and be on letterhead with physician signature).
2. ***Benefit investigations, copay assistance and prior authorizations will be handled by the RCCA precert staff if required by the payer. Please do not start the prior authorization process at your office.*** 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: All Labs Must be Completed Within the Previous 6 Months*
☐	Actemra	CBC, Hepatitis Panel, Lipid Panel, Liver Function, PPD
☐	Benlysta	None
☐	Boniva	Baseline Dental Exam, CMP, Dexa Scan within 2 years
☐	Cimzia	CBC, Hepatitis Panel, PPD
☐	Cinqair	Peak Flow and Other Pulmonary Function Tests
☐	Cytoxan	CBC, CMP, UA
☐	Entyvio	Liver Function, PPD
☐	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
☐	Inflectra	CBC, Hepatitis Panel, Liver Function, PPD
☐	IV Iron*	Reticulocyte Count, Serum Iron, TIBC, Transferrin Saturation *Feraheme, Ferrlecit, Infed, Injectafer, Verofer
☐	IVIG	Hematocrit, Hemoglobin, IgG Concentrations, Platelets, Renal Function Tests, Urine Output
☐	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
☐	Ocrevus	Hepatitis Panel; ☐ Confirm No Vaccinations within 4 Weeks of Therapy
☐	Orencia	Hepatitis Panel, PPD
☐	Prolia	Baseline Dental Exam, CMP, Dexa Scan within 2 years
☐	Provenge	PSA Level
☐	Radicava	None
☐	Reclast	Baseline Dental Exam, CMP, Dexa Scan within 2 years
☐	Remicade	CBC, Hepatitis Panel, Liver Function, PPD
☐	Rituxan	CBC, Hepatitis Panel, Renal Function Test; ☐ Confirm No Vaccinations within 4 Weeks of Therapy
☐	Simponi Aria	CBC, Hepatitis Panel, Liver Function, PPD
☐	Soliris	Meningococcal Vaccination
☐	Stelara	CBC, PPD
☐	Tysabri	MRI (MS patients), TOUCH Program Registration
☐	Xolair	Baseline Serum Ige, FEV1, Peak Flow, Other Pulm Function Test (all required for asthma indication only)