SPECIALIZED Infusion Therapy AT RCCA

*Neurology*

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.*** 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<br>*Note: All Labs Must be Completed Within the Previous 6 Months* |
|---|---|
| ☐ Boniva | Baseline Dental Exam, CMP, Dexa Scan within 2 years |
| ☐ Cimzia | CBC, Hepatitis Panel, PPD |
| ☐ Evenity | CMP, Dexa Scan within 2 years<br>☐ Confirm pt. has not had an MI or stroke within previous year |
| ☐ Inflectra | CBC, Hepatitis Panel, Liver Function, PPD |
| ☐ IV Iron* | Reticulocyte Count, Serum Iron, TIBC, Transferrin Saturation<br>*Feraheme, Ferrlecit, Infed, Injectafer, Verofer |
| ☐ IVIG | Hematocrit, Hemoglobin, IgG Concentrations, Platelets, Renal Function Tests, Urine Output |
| ☐ Nulojix | CBC, EBV Serology, Magnesium, Operative Report, Potassium, PPD |
| ☐ Ocrevus | Hepatitis Panel<br>☐ Confirm No Vaccinations within 4 Weeks of Therapy |
| ☐ Prolia | Baseline Dental Exam, CMP, Dexa Scan within 2 years |
| ☐ 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 Tests<br>☐ Confirm No Vaccinations within 4 Weeks of Therapy |
| ☐ Stelara | CBC, PPD |
| ☐ Tysabri | MRI (MS patients), TOUCH Program Registration |