

**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: \_\_\_\_\_  
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*

- 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
- Evenity  
CMP, DEXA Scan within 2 years  
 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  
\*Feraheme, Ferrlecit, Infed, Injectafer, Verofer
- Krystexxa  
G6PD Deficiency, Serum Uric Acid Levels,  
Confirm Oral Urate Lowering Agent Discontinued
- Nulojix CBC, EBV Serology, Magnesium, Operative Report, Potassium, PPD
- Orencia Hepatitis Panel, PPD
- Prolia Baseline Dental Exam, CMP, DEXA Scan within 2 years
- Reclast Baseline Dental Exam, CMP, DEXA Scan within 2 years
- Remicade CBC, Hepatitis Panel, Liver Function, PPD
- Rituxan  
CBC, Hepatitis Panel, Renal Function Tests  
 Confirm No Vaccinations within 4 Weeks of Therapy
- Simponi Aria CBC, Hepatitis Panel, Liver Function, PPD
- Stelara CBC, PPD