



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.

Insurance: ID#:

Referred by: NPI#:

Office Contact (Required): Office Ph: () - Office Fax: () -

Astera Infusion Therapy 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 the following page(s) of this form

Has the patient initiated treatment at your office? Yes No

Please note:

- A Letter of Medical Necessity may be required. If required, you will be contacted by Astera Infusion Therapy (letter must include diagnosis, previous 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. 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 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

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

- 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

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

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

- Stelara CBC, PPD

- Tysabri MRI (MS patients), TOUCH Program Registration