



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

SpecializedInfusionTherapy.com

PATIENT REFERRAL FORM

GENERAL

Patient Name: Last First Middle Pt. DOB: / /

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 6 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

If any future lab tests are needed, please provide patient with a prescription, and have patient bring on day of treatment. Results will be sent to referring physician.

Please note:

- 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).
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.
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 844.683.2244. Once all documentation is received, we will contact your patient to schedule appointment. Thanks!**

Medication                      Required Current Lab Results

*Note: Progress notes and labs must be completed within the previous 6 months for all new and renewed prescriptions.*

- Actemra      CBC, Lipid Panel, Liver Function, PPD (prior to initiation)
- Benlysta(IV)    None
- Boniva      CMP, Dexa Scan within 2 years
  - Confirm patient is in good dental health and has no outstanding dental issues
- Cimzia      CBC, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- Cinqair      Peak Flow and Other Pulmonary Function Tests
- Cytosan      CBC, CMP, UA
- Entyvio      Liver Function, PPD (prior to initiation)
- 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
- IV Iron\*      Reticulocyte Count, Serum Iron, TIBC, Transferrin Saturation \*Feraheme, Ferrlecit, Infed, Injectafer, Venofer
- IVIG      Hematocrit, Hemoglobin, IgG Concentrations, Platelets, Renal Function Tests, Urine Output  
Provide dose basis in mg/kg. Doses will be rounded to the nearest vial size available.
- 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 (prior to initiation)
- Ocrevus      CBC, prior to initiation - Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
  - Confirm No Vaccinations within 4 Weeks of Therapy
- Orencia(IV)      Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- Prolastin      Alpha 1 Proteinase Inhibitor Serum Levels and Lung Function
  - IgA antibodies negative for patient with IgA deficiency
- Prolia      CMP, Dexa Scan within 2 years
  - Confirm patient is in good dental health and has no outstanding dental issues
  - First dose
  - Continuation (provide date of last dose given)

- Radicava      None
- Reclast      CMP, Dexa Scan within 2 years
  - Confirm patient is in good dental health and has no outstanding dental issues
  - First dose
  - Continuation (provide date of last dose given)
- Remicade/Inflectra (Biosimilar might be replaced if appropriate)
  - CBC, Liver Function, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- Rituxan/Riabni/Truxima/Ruxience (Biosimilar might be replaced if appropriate)
  - CBC, prior to initiation - Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
  - Confirm No Vaccinations within 4 Weeks of Therapy
- Simponi Aria(IV) CBC, Liver Function, Prior to initiation – PPD and Hep B Serology (Hep B surface antigen, Hep B surface antibody and Hep B core antibody)
- Soliris      Meningococcal Vaccination
- Stelara(IV)      CBC, PPD
- Tysabri      MRI (MS patients), TOUCH Program Registration
- Vyepti      None
- Vyvgart      CBC, Anti-AChR Antibody Positive, No Live Vaccines During Therapy
- Xolair      Baseline Serum Ige, FEV1, Peak Flow, Other Pulm Function Test (all required for asthma indication only)