Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

KRYSTEXXA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____________

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies:

____ Height:

_______________________ Weight: ________________

IS THE PATIENT G6PD DEFICIENT? ☐ **Yes** ☐ **No**
Has the patient been initiated on immunomodulation with Methotrexate or Cellcept? ☐ **Yes** ☐ **No**

Indication:
☐ M1A.09X1 Chronic gout, unspecified, with tophus (tophi)
☐ M 1A.____
☐ Other ____

DOSAGE ORDERS:
☐ 8mg IV every 2 weeks
☐ Other ____

PREMEDICATION ORDERS: *antihistamine and 125mg methylprednisolone are recommended in the PI* ☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion. ☐
Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion. ☐
Solu-Medrol: ☐ 62.5mg IVP ☐ 125mg IVP ☐ Other______ 30 min prior to infusion. ☐ Other
____

Prescriber Name: Title:

NPI:	DEA:
Prescriber Signature: Date of Order:	

Referrals will not be processed until we receive ALL the following:

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐G6PD ☐Serum Uric Acid Other: ____