Krystexxa®
Provider Order Form Rev. 07/2023
Please fax completed referral form & all required documents to (833) 786-0025



	PATIENT DE	MOGRAPHICS			
Patient Name:		DOB:	Phone:		
Address:		City/ST/Zip:			
Allergies:		☐ NKDA Weight:	□ lbs □ kg	Height:	_ 🗆 in 🗆 cm
Patient Status: ☐ New to Therapy	☐ Dose or Frequency Change	e 🗆 Order Renewal			
II.	NSURANCE INFORMATION: Please a	attach copy of insurance card	(front and back).		
		NOSIS*			
*ICD 10 Code Required					
☐ Idiopathic chronic gout (M1A.00-M1/		Chronic gout due to renal im	•	•	
Lead-induced chronic gout (M1A.10		Other secondary chronic go			
☐ Drug-induced chronic gout (M1A.20☐ Other:		Chronic gout, unspecified (M	// / A.9XXU-WITA.9XXT),	ICD10	
Li Ottler.		N OBBERG			
MEDICATION	DOSE	N ORDERS	DIRECTIONS/DURA	TION	
Krystexxa® (Pegloticase)	8 mg		ours once every 2 we		
Tayotoxxa (Fogioticaso)	5 mg		ian if uric acid >6 mg/i	-	na
			ent for 1 hour after co		-
	ah aya fuana				
Is patient currently receiving therapy another facility?	above from If yes, Faci	lity Name:			
□ NO □ YES	Date of las	t treatment:	Date of next trea	atment :	
PRE-MEDICATION ORDERS		LAB ORDERS			
Acetaminophen 650mg PO 30 minut	tes prior to infusion	Labs to be drawn by:	Infusion Center	☐ Referring Phys	sician
Diphenhydramine 25mg/50mg PO 30 minutes prior to infusion		□ No labs ordered at this	s time		
Methylprednisolone 100mg IV 30 minutes prior to infusion		☐ Serum uric acid – baseline and prior to each infusion with results			
☐ Other:		☐ Other:			
	REFERRING PHYS	ICIAN INFORMATION			
Physician Signature:			Date:		
Physician Name:	Provider NPI:_		Specialty:		
Physician Name:Address:	Provider NPI:	City/ST/Zip:	Specialty:		
Physician Name:	Provider NPI:	City/ST/Zip:	Specialty:		
Physician Name:Address:	Provider NPI: Phone #: n Should Be Sent:	City/ST/Zip:	Specialty: Fax #:		
Physician Name: Address: Contact Person: Email Where Follow Up Documentation	Provider NPI: Phone #: a Should Be Sent: REQUIRED CLINICATION	City/ST/Zip:	Specialty: Fax #:		
Physician Name:	Provider NPI: Phone #: n Should Be Sent: REQUIRED CLINIC s: Initial H&P, current MD progres	City/ST/Zip:	Specialty: Fax #:		
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