



Please fax completed form, insurance card, and clinical documentation to:
FAX: (334)284-3107

KRYSTEXXA ORDER

New Start **Maintenance: Last Dose Given** _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> 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: _____

March 2024