Krystexxa® Infusion Form

Fax Referral To: 877-438-9380

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ____________________ Next Infusion Date: ____________________

Patient Information

Patient Name:____________________________ DOB: ________________ Sex: M F Height: ______ Weight: ________________________

Phone Number: ______________________________ Email Address: ____

Allergies: ____ Is the patient Diabetic: Y N ICD-10 Code: ____________________

Emergency Contact:____ Phone Number: ____

Primary Diagnosis:

______ Chronic Gout, Without Tophus (Tophi)
______ Chronic Gout, Tophus (Tophi)
______ Other:________________________________

Please attach the following: 1. INSURANCE CARD (Front & Back) 2. PATIENT DEMOGRAPHICS 3. MOST RECENT LABS 4. MEDICATION LIST 5. H & P 6. RECENT SERUM URIC ACID (sUA) LEVELS 7. G6PD RESULTS, BASELINE URIC ACID > 6.0 mg/dL

Prior (Failed or Intolerant) Gout Therapy (if any): Allopurinol Febuxostat Probenecid Other: ____________________

Physician Information

Prescribing Physician: ________________________________ Practice Name: ________________________________
Practice Phone: ________________________________ Practice Fax: ________________________________
Email: ________________________________ Office Contact: ________________________________
Co-managing Physician: ________________________________ Phone/Email: ________________________________

Medication Order

Medication: **Krystexxa®**

RECENT DATA SUGGESTS THAT PATIENTS MAY HAVE IMPROVED OUTCOMES WHEN IMMUNOMODULATORS ARE TAKEN WITH KRYSTEXXA.

Start Dose: 8 mg in 250 mL Sodium Chloride 0.9% IV every 2 weeks

Other:__________

Pre-Medication Orders:

Diphenhydramine 25 mg IV
Methylprednisolone 1000mg IV
Other:____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ Physician's NPI#

________________________________ Physician's Address

________________________________ Prescriber's Signature

______________________ Date

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