☐ **Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ **Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225

☐ **Manhattan**
57W 57Street
Suite 601
New York, NY 10019

☐ **Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ **Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ **Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ **Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ **Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ **Holbrook/ Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ **Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

(pegloticase)

KRYSTEXXA infusion orders

Date: ____________

Patient Name ______________________ DOB ____________

Phone ______________________ J-Code J2507 M ○ F ○

NPI ______________________ Tax ID ______________________

Insurance Carrier (primary) ______________________

Insurance Carrier (secondary) ______________________

DIAGNOSIS *Please provide ICD-10 code*

☐ ________ Chronic Gout

☐ ________ ______________________ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ ______________________ *(other)*

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ ______________________ *(other)*

KRYSTEXXA ORDERS

DOSAGE/FREQUENCY

◉ 8mg IV every 2 weeks

PREMEDICATION PER PRESCRIBING INFORMATION

☐ Solu-medrol 125mg IV

☐ Diphenhydramine 25mg PO

PATIENT WEIGHT

________ lbs.

________ kg

NOTES

____

ORDERING PROVIDER

Signature **X** ______________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________

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