Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067

ThrIVewell INFUSION WEST

Office: 310-481-9944 Fax : 310-766-7001

(pegloticase)

KRYSTEXXA

Date: ____________________

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

- ☐ ________ Chronic Gout
- ☐ ________ ______________________________ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ____________________ *(other)*
- ☐ ____________________ *(other)*

KRYSTEXXA ORDERS

PATIENT WEIGHT

__________ lbs.

__________ kg

DOSAGE:

- ☐ 8mg
- ☐ Other_____________
- ☐ Total Dosage ☐ /Refills

Frequency:

- ☐ every 0,2,6,and every 8 weeks
- ☐ every_______weeks
- ☐ Other__________________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ____ Date ______________

Provider ____________________________ Phone____________ Fax ______________