

Princeton / Somerset New Jersey  
49 Veronica Avenue  
Suite 202  
Somerset, NJ 08873

Long Branch  
422 Morris Avenue  
Suite 7  
Long branch, NJ 07740

Marlton  
127 Church Road  
Suite 600  
Marlton, NJ 08053



(peglyticase)  
**KRYSTEXXA**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> 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 \_\_\_\_\_