

- Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218
- Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030
- NYC Central Park West**
115 Central Park West
Suite 15
New York, NY 10023
- Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225
- Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570
- Woodbury**
75 Froehlich Farm
Woodbury, NY 11797
- Manhattan**
57W 57Street
Suite 601
New York, NY 10019
- Elmsford/Tarrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523
- Staten Island**
27 New Dorp Lane
Staten Island, NY 10306



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Holbrook/Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741
- Long Beach**
917 Beech Street
Long Beach, NY 11561
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901
- Manhattan**
225 East 70th Street
New York, NY 10021
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- Bronx**
226 West 238th Street
Bronx, NY 10463

(peglycated)

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 _____