Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

(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 ______________