

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



(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
☐ Solumedrol 125 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 _____