Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION

Mission Medical

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
☐ 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 _____