

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



(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 <i>Please provide ICD-10 code</i> ☐ _____ 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 _____
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NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____