KRYSTEXXA REFERRAL FORM

Updated July 2019

Patient Name ______________________ Today's Date__________ ☐ *NEW* Patient ☐ *CURRENT* Patient
DOB __________ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language __________
Best Phone ______________ Email ______________________
Street Address ______________________ Apt#_____ City ______________ State _____ Zip _______
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address ______________________
Allergies ____
Current Medications including OTC's (*please fax a complete list*) ______________________

Please Fax Insurance Card(s) both sides
Insured's Name ______________________
Relation to Patient ______________________
Primary Insurance ______________________
ID# ______________ Group # ______________
Secondary Insurance ______________________
ID# ______________ Group # ______________

Ordering Prescriber ______________________
Office Contact ______________________
Street Address ______________________ Suite #_____
City ______________ State _____ Zip _______
Tel ______________ Fax ______________
Email ______________________
License# ______________________
NPI# ______________________

ICD-10 Code ☐ ______ Chronic Gouty Arthropathy with tophus (or tophi)
☐ ______ Chronic Gouty Arthropathy without tophus (or tophi)
☐ Other ____________ Diagnosis ______________________

☐ **Yes (naïve)** ☐ **No** Testing?
Results ______________________

☐ **Yes** ☐ **No** Is Patient currently on therapy?
Date of next blood work ______________________

☐ **Yes** ☐ **No** Has the patient had an inadequate clinical response reason for not completing at least a three-month trial with Probenecid alone or in combination with Allopurinol or Febuxostat?
Other reason ______________________

Required labs:
- ☐ Baseline Uric Acid is > 6.0 mg/dL
  * *Patients must have Uric Acid level drawn 24-72 hours prior to infusion*
- ☐ Baseline Glucose-6-phosphate dehydrogenase (G6PD) is __________
  * *Patients must have (G6PD) deficiency screening prior to the start of treatment*

Required labs to be drawn by:
- ☐ Infusion Clinic
- ☐ Referring Physician

PRESCRIPTION

☐ **KRYSTEXXA**
SIG: ☐ Infuse Krystexxa 8mg IV in 250mL Normal Saline IV over 120 minutes once every 2 weeks
**Patient to be observed 1 hour post infusion*

Pre-medications: ☐ IV Solu-Medrol 125mg IV, Dyphenhydramine 25mg PO/IV
**Patient is advised to take antihistamine day before infusion*

Please Note: **Patients must have Uric Acid level drawn 24-72 hours prior to infusion*
**Patients must have (G6PD) deficiency screening prior to the start of treatment*

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)______________________ **Date** __________

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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