



ax form to:

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Salt Lake City - 1.801.852.0999

### INFUSION ORDERS KRYSTEXXA (pegloticase)

Note: you must enter a 1 before the fax number

#### Patient's Information

Date of Referral

First Name

Last Name

M.I.

Date of Birth

Address

City

State

ZIP Code

Phone

WT (kg)

HT (in)

Diagnosis

Allergies

\*Please fax current medication list and H&P, G6PD, Basic Uric Acid > 6.0 mg/ds, and clinical/progress notes.

\*ICD 10 CODE

\* Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval

#### KRYSTEXXA DOSING

Krystexxa dose of 8 mg/mL

Krystexxa specific dose of

Refills:

#### Frequency

8 mg IV infusion q2wk

Specific dosing frequency of

Premedications

Prescribing Provider

Address

City

State

ZIP Code

Provider Signature

Date

Provider Phone

Provider Fax