PURE INFUSION SUITES

INFUSION ORDERS KRYSTEXXA (pegloticase)

UTAH PROVIDERS Fax form to:
1-801-991-6924

ALL OTHER PROVIDERS Fax form to:
1-801-931-2631

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