Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION
Office: 212-203-3939 Fax: 646-476-6600

REJUVEINATE

(pegloticase)

KRYSTEXXA infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ J-Code J2507 M ○ F ○

○ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Chronic Gout

☐ _____ _____ *(other)*

REFERRAL STATUS

☐ New Prescription
☐ Order Renewal
☐ Does or Frequency Change
☐ Discontinuation

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*

☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

KRYSTEXXA ORDERS

DOSAGE/FREQUENCY

◉ 8mg IV every 2 weeks
○ Other_____

PATIENT WEIGHT

_____lbs.
_____kg

PREMEDICATION PER PRESCRIBING INFORMATION

☐ Solu-medrol 125mg IV
☐ Diphenhydramine 25mg PO
○ Other_____

Total Dosages ☐ / Refills_____

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone_____ Fax _____

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