

Chicago Illinois  
4711 Golf Road  
Suite 900  
Skokie, IL 60076



(peglyticase)

Date: \_\_\_\_\_

# KRYSTEXXA

## PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> 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** *Please provide ICD-10 code*

\_\_\_\_\_ 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 \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

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### ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_  \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_