Krystexxa® Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Chronic Gout, Without Tophus (Tophi)
_____ Chronic Gout, Tophus (Tophi)
_____ Other: _____

Please attach the following: 1. INSURANCE CARD (Front & Back) 2. PATIENT DEMOGRAPHICS 3. MOST RECENT LABS 4. MEDICATION LIST 5. H & P 6. RECENT SERUM URIC ACID (sUA) LEVELS 7. G6PD RESULTS, BASELINE URIC ACID > 6.0 mg/dL

Prior (Failed or Intolerant) Gout Therapy (if any): ☐ **Allopurinol** ☐ **Febuxostat** ☐ **Probenecid** ☐ **Other:** _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: Krystexxa®

RECENT DATA SUGGESTS THAT PATIENTS MAY HAVE IMPROVED
OUTCOMES WHEN IMMUNOMODULATORS ARE TAKEN WITH KRYSTEXXA.

Start Dose: ☐ 8 mg in 250 mL Sodium Chloride 0.9% IV every 2 weeks

☐ Other: _____

Pre-Medication Orders:

☐ Diphenhydramine 25 mg IV
☐ Methylprednisolone 1000mg IV
☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date