



DATE _____ DATE NEEDED _____

SHIP TO: Patient Physician's Office HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name _____	Prescriber's Name _____
Patient Address _____	License # _____ DEA # _____
City _____ State _____ Zip _____	NPI # _____ UPIN # _____
Day Phone _____ Work Phone # _____	Practice Name _____
Cell Phone _____ E-mail _____	Office Contact _____
Date of Birth _____ SS # _____	Address _____ Suite # _____
<input type="checkbox"/> Female	City _____ State _____ Zip _____
<input type="checkbox"/> Male	Phone _____ Fax _____

DIAGNOSIS

Patient: Wt. _____ Ht. _____ Allergies: Latex Other, specify _____

ICD-10 DIAGNOSIS CODE J Code: J2507 Chronic Gouty Arthropathy w/tophus (tophi) [ICD-10 Code: _____]
 Chronic Arthropathy w/o mention of tophus (tophi) [ICD-10 Code: _____]

- Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached
- Krystexxa Service Request Form
- Baseline Uric Acid level
- Normal Glucose-6 phosphate dehydrogenase (G6PD) attached
- It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa
- Documentation of frequency and date of flares in last 18 months:

Labs: Infusion Clinic Referring Physician

Labs requested: _____

PRESCRIPTION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Krystexxa	<input type="checkbox"/> 8mg IV in 250mL of NS IV over 120 min* *Patient will be observed 1hr post infusion	<input type="checkbox"/> Initial dose: 8mg IV in 250mL of NS IV over 120 min <input type="checkbox"/> Patient will be observed 1hr post infusion <input type="checkbox"/> Frequency: every 2 wks Protocol Pre-Medication Orders: Solu-Medrol 125mg IV, Benadryl 25mg PO/IV *Patient advised to take antihistamine day before infusion *Patient must have Uric Acid level drawn 24-72 hours prior to each infusion *Patient must have Glucose-6 phosphate dehydrogenase (G6PD) deficiency screening prior to initiating therapy Additional Orders/Comments:	<input type="checkbox"/> 1 wk. supply <input type="checkbox"/> 2 wks. supply	

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ DATE _____

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.