



**PATIENT INFORMATION (Complete or Fax Existing Chart)      PRESCRIBER INFORMATION**

Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____
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**INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)**

Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____
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**CLINICAL INFORMATION**

Primary ICD-10 Code (Please specify diagnosis): \_\_\_\_\_  
 Secondary ICD-10 Code (Please specify diagnosis): \_\_\_\_\_  
 Number of Gout Flare per year: \_\_\_\_\_  Glucose-6-phosphate dehydrogenase (G6PD) Testing (Please Provide Results)  
 Serum Uric Acid Level at Baseline: \_\_\_\_\_ mg/dl Serum Uric Acid Level Prior to Infusion: \_\_\_\_\_ mg/dl  
 Is Patient Currently Prescribed and/or Taking Immunomodulation (MTX)?  Yes  No  
**Past/Current Medical History (select all that apply)**  
 CHF     BP:  Controlled  Uncontrolled     Pregnant     Breast feeding     Anaphylactic reaction to previous IV therapy  
 Tophus Joints affected: \_\_\_\_\_

**KRYSTEXXA® ORDERS**

Prescription type:  New start     Restart     Continued therapy    Total Doses Received: \_\_\_\_\_    Date of Last Injection/Infusion: \_\_\_\_\_

Medication	Dose/Frequency	Refills
<input type="checkbox"/> Krystexxa® (pegloticase)	<input type="checkbox"/> 8 mg IV every 2 weeks <input type="checkbox"/> Other: _____	_____
<b>Pre-medication</b>	<b>Dose/Frequency</b>	<b>Refills</b>
IV Corticosteroids	<input type="checkbox"/> 40mg IV Methylprednisolone <input type="checkbox"/> 80mg IV Methylprednisolone <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____
Oral Antihistamines	<input type="checkbox"/> 60 mg fexofenadine <input type="checkbox"/> 50 mg diphenhydramine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Night before infusion, and/or can administer concomitantly with infusion <input type="checkbox"/> Other: _____	_____
Oral analgesic	<input type="checkbox"/> 1000 mg acetaminophen <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prior to each infusion <input type="checkbox"/> Other: _____	_____
<b>Anaphylaxis</b>	<b>Dose/Strength</b>	<b>Directions</b>
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 50mg IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer over at least 2 minutes as needed for mild to moderate infusion reaction <input type="checkbox"/> Other: _____
<input type="checkbox"/> Solu-Medrol	<input type="checkbox"/> 125 mg IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer over 3-5 minutes as needed for moderate to severe infusion reaction <input type="checkbox"/> Other: _____

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<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 0.3mL (0.3mg) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Administer 0.3 mg by intramuscular injection as needed for signs/symptoms of anaphylaxis. May repeat dose after 5-10 minutes if necessary <input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____

**SIGNATURE**

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

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

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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