TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

KRYSTEXXA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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: _____

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

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