hŎǘƻōŜǊ 2024

Ascend INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

KRYSTEXXA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given_____________**

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:		Fax:
Patient Name:		DOB:

Allergies ☐ NKDA ☐ Allergies: ____

Height: _________________________ Weight: _________________

IS THE PATIENT G6PD DEFICIENT? ☐ **Yes** ☐ **No**
Has the patient been initiated on immunomodulation with Methotrexate or Cellcept? ☐ **Yes** ☐ **No**

Indication:
☐ M1A.09X1 Chronic gout, unspecified, with tophus (tophi)
☐ M 1A._____
☐ Other ____

DOSAGE ORDERS:
☐ 8mg IV every 2 weeks
☐ Other ____

PREMEDICATION ORDERS: *antihistamine and 125mg methylprednisolone are recommended in the PI*

☐ Acetaminophen po:	☐ 1000mg	☐500mg		30 min prior to infusion.
☐ Diphenhydramine:	☐ 25mg PO	☐ 50mg PO	☐ 25mg IVP	30 min prior to infusion.
☐ Solu-Medrol:	☐ 62.5mg IVP	☐ 125mg IVP	☐ Other______	30 min prior to infusion.

☐ Other ____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive <u>ALL</u> the following:
☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
Most Recent Labs (within last 4-8 weeks) – Required:
☐ CBC ☐ CMP ☐G6PD ☐Serum Uric Acid Other: ____