January 2026

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: _________________

REQUIRED
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:
☐ Acetaminophen: ☐ 1000mg PO ☐500mg PO 30 min prior to infusion. -REQUIRED
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion. -REQUIRED
☐ Methylpredisolone: ☐ 62.5mg IVP ☐ 125mg IVP ☐ Other______ 30 min prior to infusion. -REQUIRED
☐ Other ____

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

Referrals will not be processed until we receive ALL 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 (within 1 month of initiation, within 48 hours for ongoing treatment
☐ Documentation of initiation of methotrexate and folic acid.
☐ Other: ____
CAUTION: Referring provider has verified patient's G6PD status__________________________