



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	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	
<input type="checkbox"/> Krystexxa® (pegloticase)	<input type="checkbox"/> 8 mg IV every 2 weeks <input type="checkbox"/> Other: _____	_____	
Pre-medication	Dose/Frequency	Refills	
IV Corticosteroids	<input type="checkbox"/> 40mg IV Methylprednisolone <input type="checkbox"/> 80mg IV Methylprednisolone <input type="checkbox"/> Other: _____	_____	
Oral Antihistamines	<input type="checkbox"/> 50 mg diphenhydramine <input type="checkbox"/> Other: _____	_____	
Oral analgesic	<input type="checkbox"/> 1000 mg acetaminophen <input type="checkbox"/> Other: _____	_____	
Anaphylaxis	Dose/Strength	Directions	Refills
<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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