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 – AND – 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.

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