

March 2024

# LOWCOUNTRY Rheumatology

A Member of Articularis Healthcare Group, Inc.

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 <input type="checkbox"/> NKDA <input type="checkbox"/> 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 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 Other: \_\_\_\_\_

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