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 ☐ 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 ☐ Lipids ☐ TB ☐ Hep B Other: _____