



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: ☐ M ☐ F Weight: _____ (lbs) Ht: _____ Allergies: _____		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)? ☐ Yes ☐ No If yes, please list immunomodulator: _____ Past/Current Medical History (select all that apply) ☐ CHF ☐ BP: ☐ Controlled ☐ Uncontrolled ☐ Pregnant ☐ Breast feeding ☐ Anaphylactic reaction to previous IV therapy ☐ Tophus Joints affected: _____ ** Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____			
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	Directions	Refills
IV Corticosteroids	☐ 40mg IV Methylprednisolone ☐ 80mg IV Methylprednisolone ☐ Other: _____	☐ Prior to each infusion ☐ Other: _____	_____
Oral Antihistamines	☐ 60 mg fexofenadine ☐ 50 mg diphenhydramine ☐ Other: _____	☐ Prior to each infusion ☐ Other: _____	_____
Oral analgesic	☐ 1000 mg acetaminophen ☐ Other: _____	☐ Prior to each infusion ☐ Other: _____	_____
ANAPHYLACTIC REACTION (AR):			
☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary ☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary			



KRYSTEXXA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

- ☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access
☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr
☐ Other: _____

SIGNATURE

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

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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