

KRYSTEXXA (Pegloticase) ORDER FORM

REFERRAL TYPE

New Referral
 Order Renewal
 Restart
 Frequency Change
 Dosage Change

PREFERRED LOCATION

<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 161 Thomas Johnson Drive Suite 250 Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006
	<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 Fairfax, VA 22031	

PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight: KG LBS	Phone:

REFERRING PHYSICIAN INFORMATION

Name:	NPI:	
Office Contact Name:	Phone:	Fax:
Address:		

KRYSTEXXA ORDER

WE DO NOT ACCEPT OFF-LABEL DIAGNOSIS, DOSE AND FREQUENCY

Dosing/Frequency:

8mg IV every 2 weeks

Diagnosis:

M1A.09X0—Idiopathic chronic gout, multiple sites, w/o tophus (tophi)
 M1A.09X1—Idiopathic chronic gout, multiple sites, with tophus (tophi)

Other Diagnosis: _____ ICD-10 Code (Required): _____

Special Instructions:

Physicians Signature: _____ Date: _____ *(Order is Valid for One Year)*

REQUIRED DOCUMENTATION

Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent labs that include values for:
 - G6PD, Uric Acid CMP and CBC
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.