TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

KRYSTEXXA ORDER FORM

Date:_____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____lbs OR _____kg

Therapy Status

Please check any of the following that apply:

☐ New Start

☐ Continuing Therapy:

Last Dose: _____

Provider Information

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

MEDICATION ORDER

Krystexxa

✓ Administer Krystexxa 8mg IV every 2 weeks over 2 hours.

☐ Methotrexate 15mg by mouth once weekly beginning 4 weeks prior to initiating Krystexxa One month supply Refills_____

☐ Folic Acid 1mg by mouth once daily

One month supply Refills_____

☐ Other:_____

☐ Immunomodulation therapy will be filled by local pharmacy

✓ Pre-medications will be given as indicated below unless otherwise specified. Antihistamine dosage and route to be determined by on site provider.

Prescriber should discontinue oral urate lowering agents prior to starting Krystexxa

Refills x one year from date of signature unless indicated below.

☐ _____ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ G6PD screening **Krystexxa should not be administered to patients who are G6PD deficient**

✓ Serum uric acid level will be drawn within 48 hours prior to each infusion.

PRE-MEDICATIONS

Oral

✓ Acetaminophen: ___325mg ___500mg __650mg
☐ Loratadine: 10 mg
☐ Cetirizine: 10mg
✓ Diphenhydramine: ___25mg ___50mg
☐ Famotidine: ___20mg ___40mg
☐ Ibuprofen: ___200mg ___400mg ___600mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_____

IV

☐ Dexamethasone: ___4mg ___8mg
✓ Diphenhydramine: ___25mg __50mg
☐ Famotidine: ___20mg ___40mg
✓ Methylprednisolone 125mg
☐ Hydrocortisone 100mg
☐ Ondansetron: ___4mg ___8mg
☐ Other_____

LAB ORDERS (Please indicate any labs to be drawn and frequency)

****Surveillance lab ordering, and monitoring is the responsibility of the prescriber****

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date