TwelveStone Health Partners
Fax Referral To:(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

KRYSTEXXA ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

Provider Information

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

MEDICATION ORDER

Krystexxa	✓ Administer Krystexxa 8mg IV every 2 weeks over 2 hours. ☐ 12Stone to fill Methotrexate and Folic Acid ☐ Methotrexate 15mg by mouth once weekly beginning 4 weeks prior to initating Krystexxa -1 month supply refills for 1 year or_____# ☐ Folic Acid 1mg by mouth once daily -1 month supply refills for 1 year or_____# ☐ Local pharmacy to fill Methotrexate and Folic Acid -Prescription sent by referring provider ☐ Other: _____ ☐ Immunomodulation therapy will be filled by local pharmacy ✓ Pre-medications will be given as indicated below unless designated otherwise. Antihistamine dosage and route to be determined by on site provider if not specified. ***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 __X__ 650mg
☐ Loratadine: _____ 10mg
☐ 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 the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date