



Order Form

Patient Information

First Name _____ Last Name _____

DOB _____ ☐ M ☐ F Phone _____ Cell _____

Address _____

Gout Diagnosis _____ ICD 10 code _____ - _____

Standing Infusion Order	
Krystexxa Dose	8 mg in normal saline 0.9% 250 ml IV over 2 hours - Patient is to be observed for 1 hr post infusion
Schedule	Infuse every two weeks x _____ months.
Labs drawn prior to each treatment 24 - 48 hrs	☐ Cbc ☐ Cmp (notify MD if Uric Acid is above 6 mg/dL.
Additional blood work requested	☐ _____
Prior to infusion:	☐ _____ mg Solu-Medro IVP ☐ _____ mg Acetaminophen PO ☐ _____ mg Benadryl IVP or PO (circle preferred) ☐ Other instructions: _____

Prescribing Physician Information

Name _____ NPI _____

Address _____

Physician Phone _____ Fax _____

Physician Signature _____ Date _____

*Prior Authorization and Verification of Benefits will be completed by our office.

*Please attach the 3 most recent MD notes, last 3 lab results, demographic sheet (including insurance information) and the completed order form. If any records are unavailable, please let us know.