Priority Health Pharmacy
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KRYSTEXXA REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ _____ Chronic Gouty Arthropathy with tophus (or tophi)
☐ _____ Chronic Gouty Arthropathy without tophus (or tophi)
☐ Other _____ Diagnosis _____

☐ **Yes (naïve)** ☐ **No** Testing?
Results _____

☐ **Yes** ☐ **No** Is Patient currently on therapy?
Date of next blood work _____

☐ **Yes** ☐ **No** Has the patient had an inadequate clinical response reason for not completing at least a three-month trial with Probenecid alone or in combination with Allopurinol or Febuxostat?
Other reason _____

Required labs:
☐ Baseline Uric Acid is > 6.0 mg/dL
** Patients must have Uric Acid level drawn 24-72 hours prior to infusion*
☐ Baseline Glucose-6-phosphate dehydrogenase (G6PD) is _____
** Patients must have (G6PD) deficiency screening prior to the start of treatment*

Required labs to be drawn by:
☐ Infusion Clinic
☐ Referring Physician

PRESCRIPTION

☐ **KRYSTEXXA**
SIG: ☐ Infuse Krystexxa 8mg IV in 250mL Normal Saline IV over 120 minutes once every 2 weeks
**Patient to be observed 1 hour post infusion*

Pre-medications: ☐ IV Solu-Medrol 125mg IV, Dyphenhydramine 25mg PO/IV
**Patient is advised to take antihistamine day before infusion*

Please Note: **Patients must have Uric Acid level drawn 24-72 hours prior to infusion*
**Patients must have (G6PD) deficiency screening prior to the start of treatment*

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.