MedicoRx Specialty & HOME INFUSION PHARMACY

Krystexxa Referral Form

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration

Patient previously treated with Krystexxa ☐ **Yes** ☐ **No**
G6PD Deficient ☐ **Yes** ☐ **No**
Previous History of Gout Treatment ______________________

Diagnosis (ICD 10) :
☐ 274.02 Chronic Gouty Arthropathy w/out mention of tophus(tophi)
☐ 274.03 Chronic Gouty Arthropathy with mention of tophus(tophi)

Other (please specify)____

Medication	Dose/Strength	Directions for Use	Quantity	Refills
☐ **Krystexxa®** (pegloticase)	☐ 8 mg	☐ Infuse Krystexxa 8 mg in normal saline 0.9% 250 ml IV over 2 hours every 2 weeks x 6 months.		

Premedications:
☐ Loratadine 10mg PO night before & morning of infusion
☐ Allegra 24hr (180mg) **OR** ☐ Allegra Q12 hr (60mg) PO night before & morning of infusion

Prior to Infusion:
☐ Solu Cortef 200 mg IVP
☐ Acetaminophen 1000mg PO
☐ Solu Medrol 40mg IVP

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**