HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

Krystexxa Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Location: ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (**check one**) ☐ M ☐ F

Home Phone: _____ Mobile Phone: _____

Email: _____ Last 4 of SS#: _____

Allergies: _____ Height: _____ Weight: _____

ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: _____ Date: _____

THERAPY ORDERS

☐ Administer Krystexxa (pegloticase) 8mg IV every 2 weeks **OR**

☐ (specify): _____

☐ Nursing per Heartland Nursing Procedures (include reaction management)

PRE-MEDICATION (per package insert)

Optional:

■ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other _____mg ☐ Tylenol (acetaminophen) _____mg PO

■ Antihistamine (**choose one**)

☐ Benadryl (diphenhydramine) _____mg ☐ IV ☐ PO

☐ Other antihistamine (**specify**): _____

LABORATORY ORDERS

■ Glucose-6-phosphate dehydrogenase (G6PD) (Provide results and date)

_____

■ Baseline Serum Uric Acid level and date (Provide results)

_____

■ Uric Acid level	■ at each dose	☐ Other: _____
☐ CBC	☐ at each dose	☐ Other: _____
☐ CMP	☐ at each dose	☐ Other: _____
☐ CRP	☐ at each dose	☐ Other: _____
☐ Other		

PRESCRIBER'S INFORMATION

Prescriber Name: _____

License #: _____ NPI: _____ DEA: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____

Office Phone: _____ Office Fax: _____

Prescriber's Signature: _____