AZIV INFUSION THERAPY CENTERS

Krystexxa (Pegloticase)

☐ New Referral ☐ Restart ☐ Medication Order Change

PATIENT INFORMATION

Name _____

Date _____

DOB _____

SS# _____

Phone # _____

Email _____

PHYSICIAN INFORMATION

Referring Physician _____

Practice Address _____

_____

Office Contact Name _____

Contact Phone # _____ Fax # _____

NPI / TIN _____ _____

MEDICATION ORDERS

Dosing: ☐ 8 mg IV Frequency: ☐ Every 2 weeks

Premeds: ☐ Antihistamine Oral ☐ Corticosteroids IV ☐ APAP Oral

Indication / Diagnosis:

☐ M1A.9xx1 Chronic gout, unspecified, with tophus (tophi)

☐ Other *(please specify in additional information)*

ICD-10 (Required) _____

MD Signature _____ Date _____

Additional Information:

_____

_____

_____

_____

_____

REQUIRED DOCUMENTATION

Please send the following documents and records. This will help streamline the pre-authorization process.

- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- G6PD
- Uric Acid
- Comprehensive metabolic panel
- CBC

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.