



# Krystexxa (Pegloticase)

INFUSION THERAPY CENTERS

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.*

**AZIVinfusion.com | CALL CENTER: 602.386.4968 | FAX: 623.594.8533**

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