KRYSTEXXA (PEGLOTICASE) Referral Form **FAX (855) 891-2191**

Effective: 10/2016

MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

_____

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

KRYSTEXXA MEDICATION ORDERS

☐ Dosing: **8** mg IV every **2** weeks.

INDICATION/DIAGNOSIS

☐ Chronic Gouty Arthropathy w/ tophus (tophi)
☐ Chronic Arthropathy w/o mention of tophus (tophi)
☐ Other (*please specify in notes*)

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

Referring office must provide Uric Acid level drawn 24-72 hours prior to each infusion.

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ G6PD ☐ Baseline Uric Acid > 6.0mg/dl ☐ CMP (w/in past 3 months) ☐ CBC with diff (w/in past 3 months)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY