



pegloticase (Krystexxa®) Order Form

FAX to 1 (888) 797-4008

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Order date:	Weight: kg	Height: m
Drug allergies: <input type="checkbox"/> NKDA. <input type="checkbox"/> YES. Please specify.		
ICD-10 diagnosis:		

LABORATORY DATA		
CBC:	BMP:	Uric acid:
G6PD assay:	Date:	Other:

pegloticase (Krystexxa®)		
Dose <input type="checkbox"/> 8 mg <input type="checkbox"/> other	Frequency <input type="checkbox"/> every 14 days <input type="checkbox"/> other:	Refills <input type="checkbox"/> please specify:

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.