Krystexxa Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ M10.9 Chronic Gout

◯ Other _____

ICD 10:_____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

KRYSTEXXA ORDER

Patients Weight: _____ kg

Krystexxa Dose: ◯ 8 mg IV **Frequency:** ◯ Every 2 weeks

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

Premeds: ☐ Benadryl 50mg PO ☐ Benadryl 50mg IV ☐ APAP 500mg PO

*** **NOTE:** Patient must have an EpiPen/ epinephrine in their possession at each appointment date.***

Date of last Krystexxa Infusions: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____