**MPP INFUSION CENTERS**
A MULTISPECIALTY PHYSICIAN COMPANY

**Fax Referrals To: (855) 891-2191**
**Email Referrals To: MPPReferral@mppinfusion.com Have a Question? (855) 478-1528**

# KRYSTEXXA® (PEGLOTICASE) ORDER FORM

*(* - Required Fields)*

_____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

| PATIENT INFORMATION | | | |
|---|---|---|---|
| NAME*: | | DOB*: | SEX: ☐ M ☐ F |
| ADDRESS: | | PHONE: | |
| WEIGHT: ☐ LBS ☐ KG | HEIGHT: | EMAIL: | |
| ALLERGIES: | | | |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| PHYSICIAN NAME*: | | PRACTICE NAME: |
| ADDRESS: | | OFFICE CONTACT*: |
| PHONE: | FAX: | EMAIL *(FOR UPDATES)*: |

## KRYSTEXXA ORDER*:

**ICD-10*:** _____

*SELECT **ONE** OF THE FOLLOWING)*

____ Dosing: 8 mg IV every 2 weeks

**Physician Signature*** _____ **Date*(Order is Valid for One Year)** _____
*Infusion will be administered per MPP policy and protocols*

## REQUIRED DIAGNOSIS:

_____ Chronic Gouty Arthropathy w/ Tophus (tophi)

_____ Chronic Gouty Arthropathy w/out Tophus (tophi)

_____ Other _____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

## REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ G6PD

_____ Baseline Uric Acid > 6.0mg/ds)

**Last Infusion/Injection Date:** _____

**STANDING LAB ORDERS:** _____ CMP _____ CBC

____ Labs to be drawn by Infusion Center Frequency _____

***NOTES/ADDITIONAL COMMENTS:***

## Locations:

--------Colorado--------
___ Lakewood

---------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Winter Park

----------Texas----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 05/2020