MPP INFUSION CENTERS
www.mppinfusion.com

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 ____ Uric Acid (Prior to every infusion)

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

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

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

------**Oklahoma**-------
___ Tulsa

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

REVISION DATE- 09/2021