Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

Fax Referrals To: (855) 891-2191
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**

Locations:

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

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 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:

REVISION DATE- 05/2020