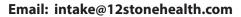
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





KRYSTEXXA ORDER FORM								
Date:		_ ICD-10 Code:				Therapy Status		
Patient Name:		Allergies:			☐ New Start			
Date of Birth:						Continuing Therapy: Last Dose:		
Provider Information								
Ordering Provider: Provider Fax:								
Provider NPI: Provider Address:								
Provider Phone:								
MEDICATION ORDER								
	✓ Administer Krystexxa 8mg IV every 2 weeks over 2 hours □ Other:						Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:	
Krystexxa	 ✓ Immunomodulation therapy will be filled by local pha ✓ Pre-medications will be given as indicated below und designated otherwise. Antihistamine dosage and roube determined by on site provider if not specified. 				date of signatu indicated b	for one year from f signature unless licated below. Refills	√ G6PD screening **Krystexxa should not be administered to patients who are G6PD deficient**	
	Prescriber should discontinue oral urate lowering ag prior to starting Krystexxa			gents			Serum uric acid level will be drawn within 48 hours prior to each infusion.	
PRE-MEDICATIONS								
Oral ✓ Acetaminophen: 325mg 500mg X 650mg □ Loratadine: 10mg □ Cetirizine: 10mg ✓ Diphenhydramine: 25mg 50mg □ Famotidine: 20mg 40mg □ Ibuprofen: 200mg 400mg 600mg □ Ondansetron: 4mg 8mg □ Other: 0ther: 0ther: 0ther:								
LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION				
Surveillance lab ordering and monitoring is the responsibility of the prescriber			(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work					
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW) By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information								
to payors with respect to this patient and prescription order. This enrollmer Dispense as Written:								
Prescriber S	signature	Date		Presc	riber Siar	nature	 Date	