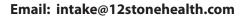
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

**Direct Phone: (844) 893-0012** 





KRYSTEXXA ORDER FORM							
Date:		ICD-10 Code:			Therapy Status  ☐ New Start		
Patient Name:		Allergies:					
Date of Birth:		. Weight:Ibs OR		_ kg	☐ Continuing Thera	ıpy: Dose:	
Provider Information							
Ordering Provider: Provid							
Provider NPI: Provider Address:							
Provider Phone:							
MEDICATION ORDER							
	✓ Administer Krystexxa 8mg IV every 2 weeks over 2 l		hours.			Place include the following	
Krystexxa	☐ 12Stone to fill Methotrexate and Folic Acid			ing 4		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:	
	☐ Methotrexate 15mg by mouth once weekly beging weeks prior to initating Krystexxa -1 month supply refills for 1 year or#						
	☐ Folic Acid 1mg by mo -1 month supply refill			Refills	for one year from		
	Local pharmacy to fill Methotrexate and Folic Acid -Prescription sent by referring provider			date of	f signature unless dicated below.	√ G6PD screening  **Krystexxa should not be administered to patients who are G6PD deficient**	
	Other:		aarmaay	,			
	☐ Immunomodulation therapy will be filled by local pha		•	-	Refills		
	Pre-medications will be given as indicated below un designated otherwise. Antihistamine dosage and ro be determined by on site provider if not specified.					Serum uric acid level will be drawn within 48 hours prior to	
	**Prescriber should discontinue oral urate lowering a prior to starting Krystexxa**		gents			each infusion.	
PRE-MEDICATIONS							
<u>Oral</u> <u>IV</u>							
✓ Acetaminophen:325mg500mgX650mg				☐ Dexamethasone:4mg8mg			
☐ Loratadine:10mg			,	✓ Diphenhydramine:25mg50mg			
Cetirizine:10mg				☐ Famotidine:20mg40mg			
✓ Diphenhydramine: 25mg50mg				✓ Methylprednisolone: 125mg			
☐ Famotidine: 20mg40mg				☐ Hydrocortisone:100mg			
☐ Ibuprofen: 200mg 400mg 600mg				☐ Ondansetron:4mg8mg			
☐ Ondansetron:4mg8mg				☐ Other:			
□ Other:  LAB ORDERS (please indicate any labs to be drawn and frequency)				OTHER REQUIRED DOCUMENTATION			
LAB ORDERS (please indicate any labs to be drawn and frequency)				(Please fax this signed order form, along with the following documents			
			to 800	to 800-223-4063)			
				History & Physical, Last Office Visit Note     Patient Demographics and Insurance Information			
			• Med	Medication List			
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  • 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 enrollment form shall serve as my signature for prior authorizations, as requested.							
Dispense as Written:				Substitution Allowed:			
Prescriber N	lame	Date	Presc	riber Nar	me	 Date	