TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

KRYSTEXXA ORDER FORM

Date: ______________________ ICD-10 Code: ______________________

Patient Name: ______________________ Allergies: ______________________

Date of Birth: ______________________ Weight: ________ lbs OR ________ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: ______________________

Provider Information

Ordering Provider: ______________________ Provider Fax: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Provider Phone: ______________________

MEDICATION ORDER

Krystexxa

- ✓ Administer Krystexxa 8mg IV every 2 weeks over 2 hours.
- ☐ 12Stone to fill Methotrexate and Folic Acid
  - ☐ Methotrexate 15mg by mouth once weekly beginning 4 weeks prior to initating Krystexxa
    -1 month supply refills for 1 year or_______#
  - ☐ Folic Acid 1mg by mouth once daily
    -1 month supply refills for 1 year or_______#
- ☐ Local pharmacy to fill Methotrexate and Folic Acid
  -Prescription sent by referring provider
- ☐ Other: ______________________
- ☐ Immunomodulation therapy will be filled by local pharmacy
- ✓ Pre-medications will be given as indicated below unless designated otherwise. Antihistamine dosage and route to be determined by on site provider if not specified.

Prescriber should discontinue oral urate lowering agents prior to starting Krystexxa

Refills for one year from date of signature unless indicated below.

________ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

- ✓ G6PD screening
  Krystexxa should not be administered to patients who are G6PD deficient
- ✓ 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: ______________________

IV

- ☐ Dexamethasone:______4mg ______8mg
- ✓ Diphenhydramine:______25mg______50mg
- ☐ Famotidine:______20mg______40mg
- ✓ Methylprednisolone: 125mg
- ☐ Hydrocortisone: ______100mg
- ☐ Ondansetron: ______ 4mg ______ 8mg
- ☐ Other: ______________________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(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 enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

______________________ ______________
Prescriber Name Date

Substitution Allowed:

______________________ ______________
Prescriber Name Date

V 09.11.24

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