KRYSTEXXA ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Social Security No. ______________________ Date of Birth ______________________

Sex □ M □ F Weight_____ Height _____ Allergies____________

Home Phone ______________________ Work/Mobile/Phone ______________________

Home Address ______________________

City ______________________ Zip ______________________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______________________ Primary Insurance Phone ______________________

Subscriber Name ______________________

Policy Number ______________________ Group Number ______________________

Prescription Card BIN # ______________________ PCN # ______________________

TREATMENT ARRANGEMENTS

Start Date:________________ Ship meds: □ Home □ Doctor's Office

Teaching By: □ Doctor's Office □ Other:__________________________

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-10 CODE):

□ M1A.9XX0 Chronic gout unspecified w/o tophus

□ M1A.00X1 Idiopathic chronic gout unspecified with tophus

□ Other: ____

Date of Diagnosis: ______________________________________

Prior (Failed) Medications:

Medication ***Strength*** ***Duration of Treatment/Reason for D/C***

□ Allopurinol ______________________________________

□ Uloric (febuxostat) ______________________________________

□ Probenecid ______________________________________

□ Other: ______________________________________

Patient Evaluation:

□ History of GPD deficient □ Yes □ No

□ Serum Uric Acid Level ____________________ Date: _________________

□ Has patient been on Krystexxa in the pas? □ Yes □ No

□ Allergies: ____

□ Concomitant Medications: ______________________________________

____

□ Other: ____

Premeds - *Patient to take antihistamine evening prior to infusion - MD to pre– medicate for gout flares*

□ Tylenol 1000mg PO □ Loratadine 10mg PO □ Benadryl ______mg IV/PO (circle one) □ Solumedrol 40mg IV

□ ***Skilled nurse to start peripheral IV prn for infusion therapy and discontinue port infusion.***

□ ***Skilled nurse to implement anaphylactic protocol per agency policy.***

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□ **Krystexxa**	□ 8mg/ml Vial	□ Infuse 8mg/ml once every 2 weeks. □ Others:	....	....

Physician Signature: x_______________________________________ □ **DAW (Dispense as Written) Date:** ______________________

Physician Name: ________________________ **Phone:** ____________________ **Fax:** ____________________ **Office Contact:** ______________

Physician Address: ____ **NPI:** ______________________ **DEA:** __________________

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