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 # _______________

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

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

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.***

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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