

Krystexxa® Infusion Form

Fax Referral To:
877-438-9380



Birmingham, AL
F: 205-271-9971

Huntsville, AL
F: 256-417-6408

Knoxville, TN
F: 865-934-0249

Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
Phone Number: _____ Email Address: _____
Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Chronic Gout, Without Tophus (Tophi)
_____ Chronic Gout, Tophus (Tophi)
_____ Other: _____

Please attach the following: 1. INSURANCE CARD (Front & Back) 2. PATIENT DEMOGRAPHICS 3. MOST RECENT LABS 4. MEDICATION LIST 5. H & P 6. RECENT SERUM URIC ACID (sUA) LEVELS 7. G6PD RESULTS, BASELINE URIC ACID > 6.0 mg/dL

Prior (Failed or Intolerant) Gout Therapy (if any): Allopurinol Febuxostat Probenecid Other: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: Krystexxa®

RECENT DATA SUGGESTS THAT PATIENTS MAY HAVE IMPROVED
OUTCOMES WHEN IMMUNOMODULATORS ARE TAKEN WITH KRYSTEXXA.

Start Dose: 8 mg in 250 mL Sodium Chloride 0.9% IV every 2 weeks

Other: _____

Pre-Medication Orders:

Diphenhydramine 25 mg IV

Methylprednisolone 1000mg IV

Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRX Services, Inc. All rights reserved.