Krystexxa Order Form



Fax completed form to:

| Patient Name Date of Brit Referral Date: Address: | PATIENT INFORMATION | | | | | | | |
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| PROVIDER INFORMATION Physician Rame: LC.F. DEX.F. Protice Name: IRP.F. IRP.F. Address: IRP.F. IRP.F. Supervisory Physican (if applicable): Phone: IRP.F. Patient dimong aphicable; PLEASE AT TACH Evidence of patient on concurrent immunomodulation in the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as methol treater, such as the patient's reported on the apy such as method treater, such as the patient's reported on the apy such as method treater, such as the patient's reported on the apy such as method treater, such as the patient's reported on the apy such as method treater, such as the patient's reported on the apy such as method treater, such as the patient's reported on the apy such as method to report the apy such as method to report the app treater as the patient's reported on the apy such as method to report the apy such as method tore report to find and app and the patient treater apy su | - | 10. | | | | | | |
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| PRODUCT PRESCRIPTION INFORMATION REFILLS Is this a first dose? Yes No If No, when was last dose given? When is patient due for next dose? Krystexxa 8mg IV infusion via gravity or pump over at least 2 hours every 2 weeks 8mg IV infusion, patient to have sUA level performed within 48 hours prior to each infusion. For KV0: NS 100mL via IV infusion over 1 hour. If sUA is < 6mg/dL, proceed. | (Check all that apply) Acetaminophenmg POminutes prior to infusion Solu-Medrolmg IV infusionminutes prior to infusion | | | | | | | |
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| | Krystexxa | ✓ After first infusion, patient to have sUA level performed within 48 hours prior to each infusion. For KVO: NS 100mL via IV infusion over 1 hour. If sUA is ≤ 6mg/dL, proceed. | | | | | | |
| By signing this form and utilizing our services, you are authorizing Mosaic to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies. | OTHER | | | | | | | |
| | By signing this form | | | | | | | |

Prescriber's Signature <u>Dispense as Written</u> Print Name

Date

Prescriber's Signature Substitution Permitted Print Name

ACHC

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Date

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