



Krystexxa Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills
 Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status:	New to therapy Continuing therapy	Next due date (if applicable):	

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (and year of diagnosis)

Chronic Gout (_____) ***Serum Uric Acid (SUA) and G6PD required for referral** ICD 10 (_____) Other: _____

5. PRESCRIPTION INFORMATION (requires new order every 12-months)

KRYSTEXXA

Administer 8mg every 2 weeks IV

Horizon Infusions MD will prescribe and manage Immunomodulation Therapy ***See below for required labs**

Vital signs per HI Protocol

Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg
 Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
 Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
 Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
 Prednisone _____ mg PO

Other _____

POST-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg
 Prednisone _____ mg PO

Other _____

6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
Hepatitis B	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold	Each Infusion	Other Frequency (specify): _____
Folate	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel Renal	Each Infusion	Other Frequency (specify): _____
Panel	Each Infusion	Other Frequency (specify): _____
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE