

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____

Choose Location _____

*Include recent labs and last 2 office visit notes

Name	DOB
Phone	Other Phone
Email	SSN
Allergies	Weight ☐ Lbs ☐ Kg Gender ☐ M ☐ F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name	NPI#
License #	TIN#
Address	DEA#
City	State
Office Contact	Zip
Phone	Email
	Fax

DIAGNOSIS INFORMATION:
☐ Chronic Gout

☐ Other _____

ICD 10 Code _____

*Serum Uric Acid (SUA) and G6PD required for referral

PRESCRIPTION INFORMATION (valid for 12 months)

Krystexxa

DOSING

- ☐ Administer 8mg every 2 weeks IV
☐ Vital signs per HI Protocol
☐ Anaphylaxis & Hydration Management per HI Protocol
☐ Horizon Infusions will prescribe and manage Immunomodulation Therapy

*See below for required labs

OR

☐ IMM Therapy: _____

IMM Start Date: _____

 IMM Contraindicated/Not Clinically Appropriate: ☐

(Documentation Required)

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 _____

REQUIRED LABS

- | | | | |
|---|--|--|-------|
| ☐ CBC w/ Diff | ☐ Each infusion | ☐ Other frequency | _____ |
| ☐ CMP | ☐ Each infusion | ☐ Other frequency | _____ |
| ☐ Hepatitis B | ☐ Each infusion | ☐ Other frequency | _____ |
| ☐ Quantiferon TB Gold | ☐ Each infusion | ☐ Other frequency | _____ |
| ☐ Folate | ☐ Each infusion | ☐ Other frequency | _____ |
| ☐ Other (specify): _____ | | | |

Provider Signature

Date

Fax Referrals to:

Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586