KRYSTEXXA (PEGLOTICASE) Referral Form

FAX (877) 637-6691

VASCO INFUSION

WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)* _____

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

KRYSTEXXA MEDICATION ORDERS

Dosing: ☐ **8** mg IV Frequency: ☐ Every **2** weeks.

Premeds: ☐ Antihistamine oral ☐ Corticosteroids IV ☐ APAP oral _____

INDICATION/DIAGNOSIS

☐ M1A.9xx1 Chronic gout, unspecified, with tophus (tophi)
☐ Other (*please specify in notes*)

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

****Referring office must provide Uric Acid level drawn 24-72 hours prior to each infusion.***

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ G6PD ☐ Baseline Uric Acid > 6.0mg/dl ☐ CMP (w/in past 3 months) ☐ CBC with diff (w/in past 3 months)

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY