Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Krystexxa Request Form

2301 Evesham Road, Building 800, Suite 115

Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 attn: Idyllic Infusion Coordinator

MEDICATION REQUESTED	
DATE:	
NAME OF DRUG BEING REQUESTED:	**Krystexxa**
REFERRING PROVIDER INFORMATION	
Requesting Provider Name **NPI** **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Phone Number	
Fax Number	
Practice Contact (Name/Extension/email	**Email:** Phone Number: Ext:
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Weight/Height	
Insurance(s): include copies of front and back	
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☒ Hamilton ☐ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

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Name (last, first) _____DOB: _____

ALL OF THE FOLLOWING INFORMATION IS REQUIRED :

Primary DX: Please provide diagnosis and code to the highest level of specificity

☐ M1A._____ Chronic Gout: _____

- Has the patient been test for , and found to be negative for G6PD deficiency?_____
  - If yes, please send lab results
- Has the patient failed to normalize serum uric acid? _____
- Is the patient refractory to conventional therapy? _____
- Is the patient's combination therapy of uricosuric agent (probenecid) and xanthine oxidase inhibitor at the maximum medically appropriate dose, or, alternatively, is probenecid contraindicated in this patient? _____
- Are the patient's symptoms inadequately controlled with xanthine oxidase inhibitors (allopurinol, febuxostat, etc)?_____
- Has the patient had at least 3 gout flares in the past 18 months which were inadequately controlled by colchicine and/or NSAIDS or steroids? _____
- Does the patient have at least 1 gout tophus or chronic gouty arthritis? _____
- Is the patient's baseline serum uric acid level>8 mg/dL?_____
- Will the patient concurrently receive other urate lowering therapies? _____
- What is the prescribing providers specialty?_____
- .
- If the patient is currently prescribed any immunomodulatory therapies please list them with dosage._____
- Does this patient require premedication(s)? If so, please document premedication requirements.
  - _____
- Is this patient ambulatory ? _____
  - If no, is a wheelchair required _____

PLEASE NOTE:

- Please attach a copy of the medication order to this document. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *Include all relevant chart notes, scans, tests and lab results.*
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- *-Please notify our office if medication will be discontinued.*

Ordering provider signature:

_____

ARBDA/IDYLLIC NPI: 1427622661 TAX ID: 85-1604336