



Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	PRESCRIBER INFORMATION	
Name:	DOB:	Prescriber Name:	Prescriber Name:	
		State License:	State License:	
City, State, Zip:			NPI #:Tax ID:	
Phone: Alt. Phone:			Address:	
Email: SS#:			City, State, Zip:	
	(lbs) Ht:	Phone:	Fax:	
Allergies:		Office Contact:	Phone:	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)				
Primary Insurance:		Secondary Insurance (If Applicable):	Secondary Insurance (If Applicable):	
Plan #:			Plan #:	
Group #:			Group #:	
	PCN:		PCN:	
CLINICAL INFORMATION				
Primary ICD-10 Code (Please specify diagnosis):				
Secondary ICD-10 Code (Please specify diagnosis):				
Number of Gout Flare per year: Glucose-6-phosphate dehydrogenase (G6PD) Testing (Please Provide Results)				
Serum Uric Acid Level at Baseline:mg/dl Serum Uric Acid Level Prior to Infusion:mg/dl				
Is Patient Currently Prescribed and/or Taking Immunomodulation (MTX)? \square Yes \square No				
Past/Current Medical History (select all that apply)				
□ CHF □ BP: □ Controlled □ Uncontrolled □ Pregnant □ Breast feeding □ Anaphylactic reaction to previous IV therapy				
☐ Tophus Joints affected:				
KRYSTEXXA® ORDERS				
Prescription type: New start Restart Continued therapy Total Doses Received: Date of Last Injection/Infusion:			of Last Injection/Infusion:	
Medication	Dose/Frequency		Refills	
Krystevva® (negleticase)	8 mg IV every 2 weeks Other:			
Pre-Medication	Dose/Strength	Directi	Directions	
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or	ake 1-2 tablets PO prior to infusion or post-infusion as directed	
☐ Diphenhydramine	☐ 25mg IV/PO	☐ Take 1 tablet PO prior to infusion or as o	Take 1 tablet PO prior to infusion or as directed OR	
	☐ 50mg IV/PO	·	nject contents of 1 vial IV prior to infusion or as directed	
□ Masthadana datastana	☐ 40mg ☐ 100mg		nject contents of 1 vial IV prior to infusion or as directed	
☐ Methylprednisolone	☐ 125mg	☐ Other: Inject 100mg IV 30 minutes prior	Other: Inject 100mg IV 30 minutes prior to infusion	
INFUSION REACTION ORDERS				
Mild reaction protocol:				
☐ Diphenhydramine 25mg IV, one time, for pruritus.				
If symptoms worsen, see orders for moderate to severe reactions.				
Moderate reaction protocol:				
Acetaminophen 650mg PO, one time, for pyrexia or rigors				
☑ Diphenhydramine 50mg IV, one time, for pruritus or urticaria				
☑ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms				

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If symptoms worsen, see interventions for severe reactions Severe reaction protocol: (Call 911 if initiated): ☐ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%) ☑ Diphenhydramine 50mg IV,one time, for respiratory symptoms, edema, or anaphylaxis Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis ☑ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms ☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or worsen **FLUSHING & LOCKING ORDERS** Flushing Protocol (>66lbs/33kg) PIV and Midline: Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter: ☑ 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion ☑ 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw Locking Protocol (>66lbs/33kg) PIV and Midline: PICC: Implanted Port, Tunneled Catheter, and Nontunneled Catheter: ☐ Heparin Sodium 10 units/mL 1mL IV final ☐ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush flush post normal saline flush ⋈ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush ** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused **SIGNATURE** We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Prescriber Signature

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