INTEGRATED CARE SYSTEMS
INFUSION THERAPY

KRYSTEXXA PATIENT REFERRAL FORM

PHONE 559.734.2896
FAX 559.734.6451

Patient Last Name	First Name		Today's Date	
Home Address			Prescriber	
City	State	Zip	Provider Phone #	Fax #
Home Phone #	Alternate Phone #		Nurse/Office Contact	
Social Security #	Date of Birth		Sex: ○ Male ○ Female	○ NKDA ○ Allergies

KRYSTEXXA® *pegloticase*

○ 8 mg intravenous infusion every two weeks

For _____ months

ICS COORDINATION FOR THERAPY

○ ICS to coordinate skilled nursing

CO-ADMINISTRATION MEDICATION

○ Methotrexate
○ Other

PLEASE FAX THE FOLLOWING ALONG WITH THIS ORDER

-Face sheet/Demographics
-H&P
-Labs
-Copy of Insurance Card

If you do not receive a confirmation
please call 559.734.2896
or re-fax the referral to 559.734.6451

Thank you for the opportunity to assist in the care of your patient

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment

Physician Signature **Date**