SPRINGSIDE INFUSION

Krystexxa

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis N/A
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications ☐ N/A
☐ Provider prescribed: _____

Medication order

Dose	Frequency
☐ 8 mg	☐ Every 2 weeks
☐ Other _____	☐ Other _____

Medication route ☐ IV
☐ Other _____

Lab order (Include frequency) Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | G6pd results | Serum uric acid level within 1 month for initiation of therapy, within 48 hours for ongoing treatments | Documentation of initiation of methotrexate and folic acid

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____