BluHaven HEALTH

Krystexxa Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Medication List | Most Recent Labs
Tried and Failed Therapies (including duration)

Has patient experienced at least 2 gout flares in previous 18 months? ☐ Yes ☐ No

Has patient stopped taking oral urate-lowering therapy? ☐ Yes ☐ No

Serum Uric Acid Level: _____ Date Drawn: _____

G6PD Results: _____ Date Drawn: _____ - OR- G6PD to be drawn by BluHaven ☐

Primary Diagnosis

☐ M1A.9xx0 Chronic gout, unspecified, without tophi ☐ Other: _____

☐ M1A.9xx1 Chronic gout, unspecified, with tophi

Order Information

Lab Orders (Include frequency)

*Serum uric acid levels are required within 48 hours of treatment. If not drawn in advance, the infusion clinic will draw them at the time of appointment.

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV 30 min prior to start of each infusion.

☐ Provider Prescribed: _____

Primary Medication Order

☐ Krystexxa 8mg IV every 2 weeks

☐ Other: _____

First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

☑ Start PIV/ACCESS CVC ☑ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)

☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

_____ _____

Provider Signature *Date*