

## Infusion Order Form

**Patient Information:**

\_\_\_\_\_  
**Patient Name** **DOB** **Phone Number**

**Medical Information:**

Primary Diagnosis:

Chronic Gout

ICD-10 Code: M1A.0\_\_\_\_

Other\_\_\_\_\_

ICD-10 Code: \_\_\_\_\_

Allergies: \_\_\_\_\_(or attach list)

**Clinical Information – Please include with Completed Order Form:**

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis including:
- Relevant labs and tests including:
  - G6PD Screening Results
  - Baseline serum uric acid results (sUA)
- Medication List
  - Patient to start PO methotrexate and folic acid on:\_\_\_\_\_
  - Patient to DC urate-lowering therapies on:\_\_\_\_\_

Height: _____
Weight: _____

**Krystexxa (pegloticase) Orders:**

Administer 8 mg intravenously over 2 hours every two weeks for 12 months

**Pre-Medication Orders:** Acetaminophen 650 mg, Diphenhydramine 25 mg PO and

Methylprednisolone 125 mg IV administered 30 minutes prior to infusion adjusted PRN for patient’s needs

Other:\_\_\_\_\_

**Lab Orders:**  Serum uric acid (sUA) 24-48 hours prior to each infusion

Other:\_\_\_\_\_

**Prescriber Information:**

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it’s clinical team to serve as my Prior Authorization Agent with the Patient’s Insurance Provider(s).

\_\_\_\_\_  
**Prescriber’s Signature** **Date**

\_\_\_\_\_  
**Prescriber’s Printed Name** **Contact Phone #:**

Please fax the completed order form an all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus