

# Chronic Gout Referral Form

Please send the following with clinical documentation, which includes visit, physical and history notes, plus lab results for last 3 months, to:

p: 844.575.1515 | f: 844.797.5050 | e: [specialtyreferrals@soleohealth.com](mailto:specialtyreferrals@soleohealth.com)

**This form is not a valid prescription**

-----<----- Please detach before submitting to a pharmacy. Cut or tear here. ----->-----

PATIENT INFORMATION					
Patient Name		DOB		Contact Phone	
Address		City		State	Zip
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security, last 4 digits		Weight (lb.)		Height (in.)
<input type="checkbox"/> NKDA		<input type="checkbox"/> Allergies			Date
ICD-10 code (required)			ICD-10 description		
Patient Status <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy		Uric Acid Labs Attached <input type="checkbox"/> Yes <input type="checkbox"/> No		G6PD Labs Attached <input type="checkbox"/> Yes <input type="checkbox"/> No	
PRESCRIBER INFORMATION					
Ordering Prescriber			Prescriber NPI		
Practice Name			Phone		Fax
Practice Address		City		State	Zip
REQUIRED DOCUMENTATION					
<input type="checkbox"/> Insurance Cards		<input type="checkbox"/> History & Physical		<input type="checkbox"/> Most Recent Labs	
				<input type="checkbox"/> Medication List	
DIAGNOSIS					
J Code: J2507					
M1A. - Chronic Gout (see full list of the most current codes at <a href="http://ChronicGoutCodes.com">ChronicGoutCodes.com</a> )					
<input type="checkbox"/> Yes <input type="checkbox"/> No - Does patient have a diagnosis of asymptomatic hyperuricemia or a deficiency in G6PD?					
If yes, patient is not a candidate for Krystexxa.					
CHRONIC GOUT TREATMENT PLAN					
<input type="checkbox"/> Krystexxa®					
Dose: 8mg/50ml Ready to Use vial					
• Registered nurse to infuse intravenously over no less than 120 minutes every 2 weeks					
• Patient will be monitored by a registered nurse 2 hours post infusion					
<input type="checkbox"/> Other					
Include dosage, frequency and any other special instructions.					
<input type="checkbox"/> Refill for 1 year					
NURSING					
Skilled RN to establish and maintain vascular access as needed, draw ordered labs, conduct patient assessments, and educate on home infusion, medication administration, self-monitoring and safety.					
PREMEDICATION			LABORATORY ORDERS		
<input type="checkbox"/> Include premedication per Pharmacy's infusion protocol.			<input type="checkbox"/> CBC every _____		
<input type="checkbox"/> Other _____			<input type="checkbox"/> Uric Acid level		
			<input type="checkbox"/> CMP every _____		
			<input type="checkbox"/> Other		

The Pharmacy may contact the prescriber to comply with state-specific requirements. The prescriber is required to comply with any applicable state-specific prescription requirements (e.g., e-prescribing, prescription forms).

The information in this form is intended only for the person(s) or entity to which it is addressed and may contain confidential or legally protected material. If you receive this information in error, please contact the sender and destroy the document(s) promptly at the direction of the sender.