OAOC
INFUSION CENTER

Krystexxa ® | (Pegloticase)

## Please fax a copy of the following patient information:

☐ Demographics ☐ Insurance information ☐Current Lab Results ☐H&P ☐ Current Medication

## Patient Information

Patient Name:_____ DOB:_____
Allergies:_____ Weight: _____ lbs/kg Height:_____
Diagnosis/ ICD-10:
☐ Chronic gout, unspecified, without tophus (tophi) / M1A.9XX0
☐ Other (please specify) _____
Additional information:
_____

## Provider Information

Printed Provider's Name:
_____
Phone: _____ Fax:_____
Office Address:
_____
Contact Person:_____

## Medication Information

Dose:_____ Frequency and Duration: _____
Start Date of Infusion:_____ End Date of Infusion:_____
Other Orders or Special Instructions:
_____

2100 116th AVE NE
Bellevue, WA 98004
Phone: (425) 453-0766
Fax: (425) 451-3560

OVERLAKE
ARTHRITIS, OSTEOPOROSIS & INFUSION CENTER