**Fax**

|  |  |  |  |
| --- | --- | --- | --- |
| TO: |  | from: |  |
| fax: |  | fax: |  |
| phone: |  | phone: |  |
| subject: | Krystexxa Referral | date: |  |
| comments | Documents needed to start the authorization process:   * Order sheet * Patient demographics including insurance information * Most recent 2-3 Office Visit Notes * G6PD Lab * Uric acid levels (will need prior to each infusion) | | |