vitalcare® of the FOUR STATES

ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

_____

Signature: _____

Date: _____

PHYSICIAN ORDERS

☐ **4 WEEKS PRIOR TO STARTING KRYSTEXXA**

☐ 15 MG METHOTREXATE WEEKLY / 1 MG FOLIC ACID DAILY– **START DATE:** _____

☐ **KRYSTEXXA 8mg/50ml** **REFILLS: _____**

INFUSE OVER 2 HOURS

☐ LABS: URIC ACID

☐ **PRE-MEDICATIONS**

☐ _____

☐ _____

☐ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

DIAGNOSIS:

☐ _____ ☐ _____