LIFE SPECIALTY SOLUTIONS

KRYSTEXXA
(pegloticase)

PATIENT INFORMATION

PATIENT NAME: ______________________ PHONE #: ______________________

ADDRESS: ______________________ CITY, STATE, ZIP: ______________________

DATE OF BIRTH: ______________________ EMAIL: ______________________

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List 6. Tried/Failed Therapies

7. Has patient experienced at least 2 gout flares in previous 18 months? ☐ Y ☐ N 8. Has patient stopped taking oral urate-lowering therapy? ☐ Y ☐ N

9. Serum Uric Acid Level: _________ Date Drawn: ___________

10. G6PD Results: _____________ Date Drawn: ____________ -OR- G6PD to be drawn by Real Medix - Real Infusions ☐

PRIMARY DIAGNOSIS

☐ M1A.9xx0 Chronic gout, unspecified, without tophi ☐ M1A.9xx1 Chronic gout, unspecified, with tophi

☐ Other ______________________

LABS ORDERS: PLEASE INCLUDE FREQUENCY

*Serum uric acid levels are required within 48 hours of each treatment. If not drawn in advance, the infusion clinic will draw them at thetime of appointment.

Please list any labs to be drawn by the infusion clinic: ______________________

PRE-MEDICATIONS (30 MIN PRIOR TO EACH INFUSION)

☑ Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV

☐ Provider Prescribed: ______________________

PRIMARY MEDICATION ORDER

☐ Krystexxa 8mg IV every 2 weeks ☐ Other ______________________

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted ___________________

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: ______________________ PHONE: ______________________

OFFICE CONTACT: ______________________ FAX: ______________________

ADDRESS: ______________________ EMAIL: ______________________

CITY, STATE, ZIP: ______________________ NPI AND LICENSE: ______________________

✖ ______________________ ______________________

PROVIDER SIGNATURE DATE