



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 the time 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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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 Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.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: _____

X

PROVIDER SIGNATURE _____ DATE _____