

KRYSTEXXA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other Phone: _____

Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____ ☐ Deliver Here

Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ M1A.0 ☐ M1A.3 ☐ M1A.4 ☐ M1A.9 ☐ Other: _____

Allergies: _____ Weight: _____ ☐ Kg ☐ Lbs Height: _____ ☐ cm ☐ in

G6PD Testing: ☐ Positive ☐ Negative Date: _____ Baseline Serum Uric Acid: _____ Date: _____

Immunomodulator prescribed:

☐ Methotrexate Other: _____

It is recommended to start methotrexate with folic acid or folinic acid supplementation at least 4 weeks prior to initiating and throughout treatment.

Urate Lowering Therapy discontinued: ☐ Yes ☐ No

It is recommended to discontinue all oral urate-lowering medications prior to starting Krystexxa treatment and not institute therapy with oral urate-lowering medications while patients are currently on Krystexxa therapy.

TREATMENT INFORMATION

KRYSTEXXA (pegloticase)

Route: Intravenous Infusion

Dose: 8mg

Frequency:

☐ Once every 2 weeks

Quantity: _____ **Refills:** _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Methylprednisolone: ☐ 40mg ☐ 125mg IV

☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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