

KRYSTEXXA

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

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone: _____ **Fax:** _____

CLINICAL

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

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: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

Provider Signature: _____

Date: _____