



Rx Order Form – Krystexxa

Fax Form to (626) 999-3236

Patient Information		Prescriber Information	
Patient Name: _____		Prescriber Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Home Phone: _____		Phone: _____ Fax: _____	
Cell Phone: _____		DEA: _____ NPI #: _____	
DOB: _____ Gender: ☐ M ☐ F		Contact Person: _____	
Allergies ☐ NKDA ☐ Specify: _____			
Insurance Information (Please fax a copy of the front and back of all cards)			
Primary Insurance: _____		ID#: _____ Group: _____	
Secondary Insurance: _____		ID#: _____ Group: _____	
Prescription Card: _____		ID#: _____	BIN#: _____ PCN#: _____ Group: _____
Diagnosis (ICD-10)			
☐ M1A.9XX0 Chronic Gout, unspecified, without tophus (tophi) ☐ M1A.9XX1 Chronic Gout, unspecified, with tophus (tophi) ☐ Yes ☐ No: Does the patient have a diagnosis of asymptomatic hyperuricemia or a deficiency in G6PD? *If yes, patient is not a candidate for Krystexxa.			
Pre-Screening			
Please include most recent clinical notes and lab results for the following: ☐ G6PD Deficiency Test (to rule out Hemolysis and Methemoglobinemia) ☐ Baseline Serum Uric Acid Levels: (more than 6mg/dl) Draw labs 24-72 hours prior to the infusion. ☐ Pre-existing conditions: Monitor patients with CHF/MI closely, if applicable. ☐ Yes ☐ No: Is Patient currently on Methotrexate? How many weeks? _____. How many mg? _____. ☐ Yes ☐ No: Will oral urate-lowering treatments be discontinued before starting Krystexxa?			
Premedication			
Premedication can be given 30 minutes prior to infusion: ☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg ☐ Diphenhydramine: ☐ 25mg IV ☐ 50mg IV ☐ 25mg PO ☐ 50mg PO, or ☐ Alternate oral antihistamine: ☐ Cetirizine 10mg ☐ Loratadine 10mg. _____ ☐ Methylprednisolone ☐ 125mg IV ☐ 40mg IV OR ☐ _____mg PO; ☐ Fexofenadine 60mg, or ☐ 180mg ☐ Methotrexate 15mg weekly, or _____mg weekly to continue throughout Krystexxa therapy. ☐ Others/Miscellaneous: _____ ☐ Epinephrine pen Auto-injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis			
Medication			
☐ Krystexxa (Pegloticase) 8mg in 250ml Sodium Chloride 0.9% Solution IV over not less than 2 hours via pump every 2 weeks, followed by one hour post infusion monitoring after each dose. ☐ Cortrophin Gel . Dose: _____ Direction: _____ Refills: _____			
Flushing Protocol:			
☐ NaCl 0.9% 5-10ml IV before and after infusion ☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral/PICC access and PRN ☐ Heparin 100 units/ml 3-5ml IV after infusion for Port IV access and PRN ☐ All infusion supplies necessary to administer the medication *Skilled Nurse to assess, teach, and administer prescribed medication and admit for services.			
By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)			
_____ Prescriber Signature		_____ Date	

120 N Fairway Ln Ste A, West Covina, CA 91791 | Ph: 626-999-3636 | Fax: 626-999-3236

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intend recipient, please notify us immediately