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:
☐ 6PD 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 IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO, or ☐ Alternate oral antihistamine:
☐ Cetirizine 10mg ☐ Loratadine 10mg
☐ Methylprednisolone ☐ 125mg IVP ☐ 40mg IVP 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.

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

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