medix infusion

Krystexxa Order Form
(pegloticase)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐ M1A._____ 0 Chronic Gout, w/o Tophi

☐ M1A._____ 1 Chronic Gout, w/ Tophi

Other _____

Prescribing Information

It is recommended that the patient discontinue oral urate-lowering medications 2-3 days (up to one week) before starting Krystexxa.

Recent data suggests that patients may have improved outcomes when immunomodulators are taken with Krystexxa.

***The recommended dosage is Krystexxa 8 mg every two weeks, co-administered w/ weekly methotrexate 15 mg orally.**

***Krystexxa alone may be used in patients for whom methotrexate is contraindicated or not clinically appropriate.**

***REQUIRED*: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
***LAB RESULTS*: : G6PD, baseline uric acid > 6.0 mg/dL.**

PRESCRIPTION

Pre-Medications
Required:
Acetaminophen: 650 mg PO, may repeat q 4-6 hours, PRN infusion reaction
Diphenhydramine: 25 mg IVP, may repeat q 6 hours, PRN infusion reaction
Methylprednisolone: 125 mg SIVP
Other: _____

Lab Orders+
Required: Uric Acid Level, 24-72 hours prior to infusion
If Uric Acid Level > 6 mg/dL upon two consecutive lab draws, hold dose, and contact prescriber.
+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Krystexxa (pegloticase)

Dose:
IV: Infuse 8 mg in 250 mL of 0.9% Sodium Chloride over 2 hours, every 2 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 60 minutes following each infusion.

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____