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: _____

Diagnosis

Primary ICD 10 Code (Required)

☐ M1A.9XX0 Chronic Gout, w/o Tophi

☐ M1A.9XX1 Chronic Gout, w/Tophi

☐ Other: _____

Patient Status

☐ New to therapy

☐ Continuing therapy _____

(date of last dose _____)

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.

Medication Order

Pre-Medications (Required)

- Diphenydramine: 25 mg IVP
- Methylprednisolone: 125 mg SIVP

Additional Pre-Medications

☐ Tylenol 650 mg PO

☐ Famotidine 20 mg PO

☐ Zofran 4 mg PO

☐ Ceterizine 10 mg PO

KRYSTEXXA (pegloticase)

IV: Infuse 8 mg every two weeks for one year

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.

Lab Orders+

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

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

Comments: _____

Required Clinical Documentation

- **Signed and completed order**
- **Patient's demographic and insurance information**
- **Patient's medication list**
- **Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy**

LAB RESULTS: G6PD, baseline uric acid > 6.0 mg/dL

Is the patient on any other disease modifying therapy?

☐ Yes ☐ No

If yes, please note therapy and last dose:

_____

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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