ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

KRYSTEXXA (PEGLOTICASE) INFUSION ORDERS

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

JCode: J2501 Diagnosis ☐ Chronic Gouty Arthropathy w/tophus (tophi) (ICD-10 Code:_____

☐ Chronic Arthropathy w/o mention of tophus (tophi) (ICD-10 Code:_____

Allergies: _____ Date of last infusion: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Krystexxa service request form

☐ Baseline Uric Acid Level _____ Date of last Uric Acid Level Needed _____

☐ Normal Glucose-6-phoshate dehydrogenase (G6PD) attached

☐ It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa

☐ Documentation of frequency and date of flares in last 18 months:

_____

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Labs Orders: _____

KRYSTEXXA ORDERS

KRYSTEXXA ☐ Dose: 8mg IV in 250 ml of NS IV over 120 minutes

Patient will be observed 1 hour post infusion

Frequency: Every 2 weeks

Protocol Pre-Medication Orders: Solu-Medrol _____mg IV, Benadryl _____mg PO/IV, Cetirizine 10mg,

Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

Patient will be advised to take antihistamine day before infusion

***Patient must have Uric Acid level drawn 24-72 hours prior to each infusion**

***Patient must have a be negative after a Glucose-6-phosphate dehydrogenase (G6PD) deficiency screening prior to initiating therapy**

***Additional Orders/Comments:**

Hypersensitivity/Anaphylaxis Response Protocol PRN

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.