KRYSTEXXA (PEGLOTICASE)

INFUSION ORDERS

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

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

MEDICAL INFORMATION

JCode: J2501 Diagnosis ☐ Chronic Gouty Arthropathy w/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:

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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

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Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

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

☐ DAW (Dispense as written).

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.

Date

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance