KRYSTEXXA
(pegloticase)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____ lbs or_____kg	Patient's Email:

REQUIRED DOCUMENTATION

•Insurance Card •H&P •Patient Demographics •Most Recent Labs •Medication List •Tried/Failed Therapies

- •Has patient experienced at least 2 gout flares in previous 18 months? ☐ Y ☐ N
- •Has patient stopped taking oral urate-lowering therapy? ☐ Y ☐ N
- •Serum Uric Acid Level: _____ Date Drawn: _____
- •G6PD Results: _____ Date Drawn: _____

PRIMARY DIAGNOSIS

☐ M1A.9xx0 Chronic gout, unspecified, without tophi
☐ M1A.9xx1 Chronic gout, unspecified, with tophi
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

·Serum uric acid level lab results are required within 48 hours of treatment. If not drawn in advance, the infusion clinic will contact provider to order labs for patient.

PRE-MEDICATIONS (30 min prior to each infusion)

*Per infusion clinic protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, Methylprednisolone 100mg IV
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Krystexxa 8mg IV every 2 weeks
☐ Other: _____

First Dose: ☐Y ☐ N
☑ Refill x12 months unless otherwise noted: _____

SUPPORTIVE THERAPIES

Immunomodulators to be prescribed & managed by:
☐ Infusion Clinic ☐ Referring Provider

Gout Flare Treatment:
☐ Colchine 0.6mg PO BID PRN gout flares
☐ Medrol Dose-pak PRN gout flares
☐ Naproxen 500mg PO BID PRN gout flares
☐ Ilaris 150mg subQ every 12 weeks x _____doses

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI and License:	☐ Email:

Provider Signature _____ Date _____