# Krystexxa® (pegloticase) Referral Form

Please complete the following and fax with clinical documentation to:
720.279.7461

## Referral Process

| 1. PATIENT INFORMATION | 2. PHYSICIAN INFORMATION |
|---|---|
| Name: ____________ | Physician's name: ____________ |
| Address: ____________ | License #: ________ NPI #: ________ |
| City: ________ State: _____ Zip: ___ | DEA #: ____________ |
| Home Phone: ________ Other Phone: ____ | Address: ____________ |
| Email: ____________ | City: ________ State: _____ Zip: _______ |
| DOB: ________ Social Security #: ________ | Office Contact: ____________ |
| Gender: ☐ M ☐ F Height: _____ Weight: _____ | Phone: ________ Fax: ________ |

**3. DIAGNOSIS**

**J Code: J2507**

M1A. __________ - Chronic Gout (see full list of the most current codes at ChronicGoutCodes.com)

☐ Yes ☐ No Does patient have a diagnosis of asymptomatic hyperuricemia or a deficiency in G6PD?
If yes, patient is not a candidate for Krystexxa.

**4. INSURANCE INFORMATION**

**Please submit copies of the front and back of primary and secondary insurance cards with this referral.**

**5. PLEASE ATTACH ADDITIONAL INFORMATION REQUESTED**

Allergies: ______________________________

☐ Clinical/Progress Notes, Labs, tests supporting primary diagnosis
☐ Baseline Uric Acid level
☐ Normal Glucose-6 phosphate dehydrogenase (G6PD)
☐ It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa
☐ Documentation of frequency and date of flares in last 18 months (either attach or document here):

______________________________

**PRESCRIPTION INFORMATION Anticipated start date:** __________

**Krystexxa® ***

☐ **Dose**: 8mg/250mL 0.9% Sodium Chloride or 0.45% Sodium Chloride

- Registered nurse to infuse intravenously over no less than 120 minutes every 2 weeks
- Patient will be monitored by a registered nurse 2 hours post infusion

☐ **Protocol Pre-Medication Orders:**

- Pre-Medication Orders: Solu-Medrol 125mg IV, Benadryl 25mg PO/IV
- Patient advised to take antihistamine day before infusion
- Patient must have Uric Acid drawn 24-72 hours prior to each infusion
- Patient must have Glucose-6-phosphate dehydrogenase (G6PD) deficiency screening prior to initiating therapy

**FLUSH ORDERS**

**PIV/midline/PICC:** Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
☐ Heparin 10 unit/ml ☐ Heparin 100 unit/ml

**Port:** Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

**ANAPHYLAXIS ORDERS**

**Adults**: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.
For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

☐ Other: ________________

**Labs:** Required labs to be drawn by: ☐ Soleo Health ☐ Referring Physician

**Lab Orders:** ____________________________________________

**Additional Orders/Comments:**

____________________________________________

6. ☐ Dispense as written ☐ Substitution Permitted

**PHYSICIAN'S SIGNATURE (required):** ______________________ **DATE:** ______________


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Prescription is valid for one year unless otherwise indicated. The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.