Krystexxa® (pegloticase) Referral Form

Please complete the following and fax with clinical documentation to: 720.870.2414

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.