Krystexxa

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Notes, Medication List, Insurance Information, Krystexxa Patient Enrollment Forms

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ Chronic Gout ☐ M1A.00X0 ☐ M1A.00x1 ☐ M1A.9XX0 ☐ M1A.9XX1 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

- ☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI
- ☑ Glucose-6-Phosphate Dehydrogenase (G6PD) _____
- ☑ Krystexxa Patient Enrollment Forms
- ☑ Baseline Serum Uric Acid Level _____

PRE-MEDICATION ORDERS

I4H recommends per PI to start weekly methotrexate and folic acid or folinic acid supplementation at least 4 weeks prior to initiating, and throughout treatment.

- ☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
- ☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO
- ☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV
- ☐ Loratadine ☐ 10mg PO
- ☐ Cetirizine ☐ 10mg PO
- ☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

- ☑ Uric Acid Level ☑ 2-3 days prior to each infusion
- ☐ CBC ☐ at each dose ☐ every _____
- ☐ CMP ☐ at each dose ☐ every _____
- ☐ Other _____ ☐ every _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☑ Krystexxa Intravenous Infusion

Dose: 8mg in 250mL 0.9% sodium chloride
Route: IV
Frequency: ☐ Every 2 weeks ☐ Other: _____

☑ Infuse over 2 hours

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) | Provider Signature | Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***