Krystexxa
(pegloticase)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Chronic Gouty Arthropathy w/tophi (M1A.9xx1)

☐ Chronic Arthropathy w/o mention of tophi (M1A.9xx0)

☐ Other: _____

PRESCRIPTION

Krystexxa (pegloticase)

☐ 8mg IV every 2 weeks **Patient to be observed 1 hour post infusion**

☐ Other: _____

Has patient received any doses of this medication in the past?

☐ Yes ☐ No

☑ Refill x 12 months unless otherwise noted: _____

_____

Supportive Therapies

Immunomodulators to be prescribed and managed by:

☐ Infusion Clinic ☐ Referring Provider

Gout Flare Treatment:

☐ Colchicine 0.6mg PO BID PRN gout flares

☐ Medrol Dose-pak PRN gout flares

☐ Naproxen 500mg PO BID PRN gout flares

☐ Ilaris 150mg SC every 12 weeks x _____ doses

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Tried/failed therapies
- Serum uric acid level results
- G6PD results
- Has patient experienced at least 2 gout flares in previous 18 months? ☐ Yes ☐ No
- Has patient stopped taking oral urate-lowering therapy? ☐ Yes ☐ No

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. *(See aiscaregroup.com for detailed policy)*

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: Acetaminophen 650mg PO, Diphenhydramine 25mg IV, methylprednisolone 100mg IV 30 min prior to start of each infusion.

☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

Serum uric acid levels are required within 48 hours of treatment. If not drawn in advance, the infusion clinic will draw them at the time of appointment

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.