Krystexxa®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Idiopathic chronic gout (M1A.00-M1A.09), ICD10 _____

☐ Lead-induced chronic gout (M1A.10-M1A.19), ICD10 _____

☐ Drug-induced chronic gout (M1A.20-M1A.29), ICD10 _____

☐ Other: _____, ICD10 _____

☐ Chronic gout due to renal impairment (M1A.30-M1A.39), ICD10 _____

☐ Other secondary chronic gout (M1A.40-M1A.49), ICD10 _____

☐ Chronic gout, unspecified (M1A.9XX0-M1A.9XX1), ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Krystexxa® (Pegloticase)	8 mg	Infuse IV over 2 hours once every 2 weeks x 1 year ☐ Notify physician if uric acid >6 mg/mL before infusing ☐ Observe patient for 1 hour after completion of infusion

Is patient currently receiving therapy above from another facility?

☐ NO ☐ YES

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment :_____

PRE-MEDICATION ORDERS

- Acetaminophen 650mg PO 30 minutes prior to infusion
- Diphenhydramine 25mg/50mg PO 30 minutes prior to infusion
- Methylprednisolone 100mg IV 30 minutes prior to infusion

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ Serum uric acid – baseline and prior to each infusion with results

☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ The patient has refractory chronic gout as evidenced by the following:

- ☐ History of at least 2 gout flares in the previous 12 months
- ☐ At least 1 gout tophus
- ☐ Gouty arthritis
- ☐ Other: _____

☐ The patient has a baseline serum uric acid of ≥ 6 mg/dL prior to initiating Krystexxa.

☐ The patient does not have Glucose-6-phosphate dehydrogenase (G6PD) deficiency.

☐ Krystexxa will be co-administered with weekly oral methotrexate unless there is a documented contraindication.

LAB and TEST RESULTS (required)

☐ Baseline serum uric acid level

☐ Glucose-6-phosphate dehydrogenase (G6PD) test

☐ Other: _____

PRIOR FAILED THERAPIES FOR CHRONIC GOUT

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____