Fax Form to: 330-294-2082

INDY INFUSION

Pegloticase (Krystexxa)

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA 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 Code:

NURSING

☑ Provide nursing care per Nursing Procedures, including reaction management and post-procedure observation

☑ Baseline Serum Uric Acid level and date (Please provide results):
_____

☑ Glucose-6-phosphate dehydrogenase (G6PD) results and date (Please provide results):
_____

☑ Please indicate if patient is currently prescribed any immunomodulator therapy such as: methotrexate, mycophenolate, leflunomide, azathioprine, or cyclosporine:
_____

☑ Evidence supports the combination of Krystexxa and an immunomodulator in improving the patient's response to therapy; consider adding an immunomodulator if clinically appropriate.

RECOMMENDED PRE-MEDICATION ORDERS

The following pre-medications are recommended by the manufacturer as a standard premedication regimen.

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

SPECIAL INSTRUCTIONS

ADDITIONAL PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

LABORATORY ORDERS

☑ Uric acid ☑ at each dose
☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☑ **Pegloticase** (Krystexxa) in 250ml 0.9% sodium chloride, intravenous infusion over 120 minutes
- Dose: 8mg
- Route: ☑ intravenous
- Frequency: ☐ every 2 weeks / ☐ other: _____
- Infuse over no less than 120 minutes

☑ Flush with 0.9% sodium chloride at the completion of infusion
☑ Patient is required to stay for one-hour observation period
☐ Refills: ☐ Zero / ☐ for 6 months / ☐ for 12 months / ☐ Other:
_____ (if not indicated order will expire one year from date signed)

*Patients should be pre-medicated with antihistamines and corticosteroids. *Monitor serum uric acid levels prior to infusions. Consider ceasing treatment if levels increase above 6 mg/dL, especially if 2 consecutive levels above 6 mg/dL are observed. *Screen patients at risk for G6PD deficiency prior to starting KRYSTEXXA. Hemolysis and methemoglobinemia have been reported with KRYSTEXXA in patients with G6PD deficiency. Do not administer KRYSTEXXA to patients with G6PD deficiency. *Observation of patients for approximately an hour post-infusion should be considered.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Krystexxa:
*Perform serum uric acid (sUA) test prior to each infusion
*Screen patients at risk for G6PD deficiency prior to starting therapy
*Patient had chronic gout and is an adult patient who have failed to normalize serum or has shown an inadequate response to conventional therapy