

**PRESCRIPTION ORDER FORM**

**KRYSTEXXA**  
**(pegloticase)**



215 Pleasant Street, 5th Floor, Fall River, MA 02721  
Phone: (508) 567-5666 | Fax: (508) 567-5614

**PATIENT DEMOGRAPHICS**

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

**REQUIRED DOCUMENTATION**

• Insurance Card • History & Physical • Patient Demographics • Most Recent Labs • Medication List • Tried/Failed Therapies

- Has patient experienced at least 2 gout flares in previous 18 months?  Y  N
- Has patient stopped taking oral urate-lowering therapy?  Y  N
- Serum Uric Acid Level: \_\_\_\_\_ Date Drawn: \_\_\_\_\_
- G6PD Results: \_\_\_\_\_ Date Drawn: \_\_\_\_\_ - OR- G6PD to be drawn by FlexCare

**PRIMARY DIAGNOSIS**

- M1A.9xx0 Chronic gout, unspecified, without tophi  Other: \_\_\_\_\_
- M1A.9xx1 Chronic gout, unspecified, with tophi

**LAB ORDERS: PLEASE INCLUDE FREQUENCY**

- CBC w/ diff & ANC: \_\_\_\_\_  LFT's at month 2 then every 3 months after  Other: \_\_\_\_\_

**PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)**

- Diphenhydramine 25mg PO or IVP & 50mg PO or IVP  Cetirizine 10mg PO  Pepcid 20mg PO or IVP
- Solu-Medrol 40mg IVP  Solu-Cortef 125mg IVP  Tylenol 650mg PO  Other: \_\_\_\_\_

**PRIMARY MEDICATION ORDER**

- Krystexxa 8mg IV every 2 weeks infuse over 2 hours
- Other: \_\_\_\_\_
- First Dose:  Y  N
- Refill x12 months unless otherwise noted: \_\_\_\_\_

**SUPPORTIVE THERAPIES**

- Immunomodulators to be prescribed & managed by:
  - Infusion Clinic  Referring Provider
- PRN Gout flare treatment:
  - Colchine 0.6mg PO BID PRN gout flares
  - Medrol Dosepak PRN gout flares
  - Naproxen 500mg PO BID PRN gout flares

**LINE USE/CARE ORDERS**

- Start PIV/ACCESS CVC  Flush device per Suite Life Health's protocol (See [suitelifehealth.com](http://suitelifehealth.com) for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

**ADVERSE REACTION & ANAPHYLAXIS ORDERS**

- Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See [suitelifehealth.com](http://suitelifehealth.com) for detailed policy)
- Other: Please fax other reaction orders if checking this box

**PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION**

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature

Date

