immersiv HEALTH

# KRYSTEXXA® ORDER FORM

**FAX TO: 855.694.4656**

## PATIENT INFORMATION

**PATIENT NAME:** _____ **PHONE:** _____

**DATE OF BIRTH:** _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

**ALLERGIES:** _____ **PREFERRED CLINIC:** _____

**REFERRAL STATUS:** ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

## DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

☐ M1A. ___ Chronic Gout

☐ ICD-10 CODE: _____ DESCRIPTION: _____

Is patient prescribed methotrexate or other immunomodulation therapy? ☐ YES ☐ NO

## REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & failed Therapies ☐ Most recent History & Physical ☐ G6PD ☐ Baseline serum uric acid

## MEDICATION ORDER

☐ Krystexxa® (pegloticase) 8 mg IV in 250 ml NS over 2 hours every 2 weeks

**LABS**

☑ Obtain serum uric acid level (sUA) 24-48 hours prior to each infusion
*Dose will be held if 2 consecutive serum uric acid levels are above 6 mg/dL

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

### PRE-MEDICATIONS

**REQUIRED**

| | | |
|---|---|---|
| ☑ Acetaminophen: 650 mg | ☑ PO | ☐ IV |
| ☑ Diphenhydramine: 25mg | ☐ PO | ☑ IV |
| ☑ Methylprednisolone: 125mg | ☐ PO | ☑ IV |

**OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 60 minutes following each administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

## PRESCRIBER INFORMATION

**PROVIDER NAME:** _____ **NPI #:** _____

**EMAIL:** _____ **PHONE:** _____ **FAX:** _____

**ADDRESS (INCLUDE CITY, STATE, ZIP):** _____

**SUPERVISING PHYSICIAN:** _____ **CONTACT NAME:** _____
(IF APPLICABLE)

**SIGNATURE:** _____ _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN