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

Date the patient started methotrexate or other immunomodulation therapy: _____

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 / 50 mL IV over a minimum of 2 hours every 2 weeks

LABS

☑ Obtain serum uric acid level (sUA) within 72 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. Administer per protocol.
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