Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Krystexxa Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Chronic Gouty Arthropathy w/tophus (tophi) ICD-10:_____
- ☐ Chronic Arthropathy w/o mention of tophus (tophi) ICD-10:_____
- ☐ Other:_____ICD-10:_____

ORDER FOR KRYSTEXXA (PEGLOTICASE):

- ☑ **8MG IV in 250ML 0.9% NACL over 120 minutes every 2 weeks x 1 year**

***Labs must be drawn 2-3 days prior to infusion.*
If uric acid > 6mg/dl x 1, infusion approval must be given by a prescribing provider.
If uric acid > 6 mg/dl x 2 consecutive draws, infusion will NOT be given.

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg IV or PO or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed Provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
- ☐ Supporting documentation to include past tried and/or failed therapies
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
- ☐ Will the patient co-administer methotrexate or other immunomodulation therapy?
  ☐ Yes ☐ No
  If yes, which drug? _____
- ☐ Documentation of frequency and date of flares in the last 18 months (please include documentation):
  _____
- ☐ Has the patient tried and failed Allopurinol/Uloric, Colchicine, or Probenecid?
  ☐ Yes OR ☐ No
  If yes, which drug(s)? _____

Additional REQUIRED Information:

- ☐ Labs attached, including:
  - ☐ Baseline serum uric acid (required)
  - ☐ G6PD serum level (required)
  - ☐ It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa

- ☐ Other medical necessity: _____

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