**Nevada Infusion**
**Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511**
**Carson Location - 180 E Winnie Lane, Carson City, NV 89706**
**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:_____

**PRE-TREATMENT REQUIREMENTS:**

- ☐ Negative G6PD deficiency test (attach documentation)
- ☐ Baseline serum uric acid (sUA) level: _____ mg/dL Date: _____ /_____ /_____
- ☐ No history of serious hypersensitivity reactions, including anaphylaxis, to KRYSTEXXA or any of its components
- ☑ **Ordering Provider will provide the patient with the following prescriptions/lab orders unless contraindicated:**
  - ☐ Methotrexate 15 mg PO once weekly beginning at least 4 weeks prior to first infusion
    Date immunomodulator was started: _____ /_____ /_____
  - ☐ Folic acid 1mg PO once daily beginning at least 4 weeks prior to first infusion
  - ☐ Daily treatment with either colchicine or NSAID beginning 1 week prior to first infusion for gout flare prophylaxis
  - ☐ Standing lab orders for sUA every 2 weeks for the duration of anticipated Krystexxa therapy

**PREVIOUS 3-MONTH TRIAL OF:**

☐ Allopurinol ☐ Febuxostat ☐ Probenecid ☐ N/A; contraindicated ☐ Hypersensitive, or non-candidate

**INFUSION MONITORING:**

- ☑ Hold infusion and notify prescriber if 2 consecutive sUA levels >6 mg/dL
- ☑ Infuse KRYSTEXXA intravenously over at least 120 minutes. If infusion reaction occurs, stop infusion, monitor patient, and treat per orders/protocol as clinically indicated
- ☑ Discontinue all oral urate-lowering medications prior to Krystexxa treatment
- ☑ Observe the patient post infusion for 1 hour observation time.

**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:_____

**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: _____

**ORDER FOR KRYSTEXXA (PEGLOTICASE):**

- ☑ **8MG (1ML) IV in 250ML 0.9% NACL over 120 minutes every 2 weeks x 1 year**
- ☐ **Other**: _____

**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:**

- ☑ Standing order: sUA level within 48 hours prior to each infusion - (after the first infusion)

***Labs must be drawn 48 hours 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.*

- ☐ Additional Lab Orders: _____

Fax results to: _____

**PROVIDER INFORMATION:**

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

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# Krystexxa Order Form

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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