Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Krystexxa® (pegloticase) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ M1A._____ - Chronic gout, without tophi
- ☐ M1A._____ - Chronic gout, with tophi
- ☐ M10._____ - Idiopathic gout
- ☐ _____- Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Baseline serum uric acid level		☐ **Continue current order until insurance approved**
6	G6PD serum level		
7	Specify if patient is prescribed prophylaxis for gout flare:	8	Specify if patient is prescribed methotrexate or other immunomodulation therapy:

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive KRYSTEXXA® if patient has a diagnosis of G6PD or has new or worsening symptoms of CHF.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMNISTRATION AS SELECTED

Manufacturing guidelines suggest the administration of IV corticosteroids and antihistamine prior to administration of Krystexxa®.

IV	Diphenhydramine	☐ 25mg	☐ 50mg			
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:		
	Famotidine	☐ 20mg	☐ 40 mg			
	Other:	☐				

PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg	
	Famotidine	☐ 20mg	☐ 40mg			
	Diphenhydramine	☐ 25mg	☐ 50mg			
	Fexofenadine	☐ 60mg	☐ 180mg			
	Cetirizine	☐ 10mg				
	Loratadine	☐ 10mg				
	Other:	☐				

MEDICATION/DOSE:

☑ Krystexxa® (pegloticase) 8 mg in 250ml NS IV to infuse over 2 hours

Monitor patient for one (1) hour post infusion completion.

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

Serum uric acid level preferred 48 hours prior to each infusion. Hold infusion if 2 consecutive levels are above 6 mg/kL.

FREQUENCY:

- ☐ Dosing every 2 weeks
- ☐ Other: _____

SPECIAL/LAB ORDERS:

- ☐ _____
  _____

If 2 doses (4 weeks) of therapy are missed, then referring provider must give written clearance to resume therapy or treatment will be discontinued.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

ACCURX
INFUSION CENTER
A PALMETTO INFUSION COMPANY

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023