

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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 ADMINISTRATION AS SELECTED

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

IV	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					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 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	_____ DATE:
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Palmetto

INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com