FLOMED INFUSION

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KRYSTEXXA (pegloticase)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____

Required Labs: Baseline Uric Acid, Normal Glucose-6 Phosphate Dehydrogenase (G6PD)

DETAILS NEEDED FOR AUTHORIZATION

- Patient must discontinue oral urate-lowering medications before starting Krystexxa.
- Proof of patient being concurrently treated with any other biologic: _____
- Frequency and dates of flares for the last 18 months

KRYSTEXXA (pegloticase) ORDERS

☐ Dose: 8mg IV in 250mL of NS IV over 120 minutes
* Patient will be observed for 1 hour post infusion

Frequency: Every 2 weeks
Pre-Medication Orders: Solu-Medrol 125mg IV, Benadryl 25mg PO/IV
* Patient advised to take antihistamine day before infusion
* Patient must have Uric-Acid level drawn 24-72 hours prior to each infusion

Additional Orders/Comments: _____

_____

_____

_____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____