Pegloticase (Krystexxa)

Provider Order Form rev. 12/19/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Gouty arthropathy:

Other: Description:

REQUIRED INFORMATION

☑ G6PD Results _____

☑ Baseline uric acid level _____ & date _____

THERAPY ADMINISTRATION & DOSING

☐ Krystexxa 8mg IV every 2 weeks with weekly oral methotrexate 15mg and daily folic acid 1mg[1]

☐ Methotrexate contraindicated and patient is on Krystexxa Monotherapy 8mg IV every 2 weeks

☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion

[1]Begin weekly Methotrexate and Folic Acid 4 weeks prior to the start of Krystexxa infusions.

FREQUENCY *(Choose one)*

☐ Every 2 weeks

☐ Other: _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ Obtain serum uric acid level prior to each infusion (or may use result obtained within 48 hrs prior to infusion).

☐ Other: _____

PRE-MEDICATION ORDERS

☑ All premedication administered 30mins prior to infusion

☐ Loratadine 10mg PO

☐ Tylenol 500mg PO

☐ Solumedrol 125mg IV

☑ Benadryl ☐ 25 mg / ☐ 50mg ☐ PO / ☐ IV ***(must have per PI)***

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Uric acid level greater than 6 mg/dL for 2 consecutive treatments (lab orders below).
- Patient has had more than 4 weeks between treatments (due to increased risk for adverse reaction).
- Patient reports continued use of uric acid lowering agents (allopurinol, febuxostat, probenecid, etc.)
- Hypertension (170/90 or symptomatic)

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with colchicine, NSAIDs, steroids, Febuxostat, Allopurinol, Probenecid. flares in 12 months, Gouty arthritis, Tophus **Required Labs:** G6PD, UA level, CRP/ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.