# Krystexxa® Referral Form

Phone: (877) 246-9104
Fax: (800) 783-9146
WWW.Biotekrx.com

| PATIENT INFORMATION (Complete or fax existing chart) | PRESCRIBER INORMATION |
|---|---|
| Patient Name: _____ | Prescriber Name: _____ |
| Address: _____ | State License: _____ NPI #: _____ |
| City, State, Zip: _____ | DEA: _____ Phone: _____ |
| Phone: _____ 2nd Phone: _____ | Specialty: _____ Fax: _____ |
| DOB: _____ Gender: ☐ Male ☐ Female | Address: _____ |
| Weight: _____ Ht: _____ | City, State, Zip: _____ |
| Allergies: _____ | Contact Person: _____ Phone: _____ |

| INSURANCE INFORMATION - OR - Send a copy of the patient's prescription / insurance cards (front & back) | |
|---|---|
| Primary Insurance: _____ | RX Card (PBM): _____ |
| City, State, Zip: _____ | BIN: _____ PCN: _____ |
| Plan #: _____ Group #: _____ | City, State, Zip: _____ |
| Phone: _____ | Group #: _____ Phone: _____ |

**DIAGNOSIS / CLINICAL INFORMATION**

Diagnosis: _____ ICD-10 Code(s): _____

**KRYSTEXXA® INFUSION ORDERS**

| | |
|---|---|
| **Dose / Schedule** | 8 mg given as an intravenous infusion every 2 weeks Refills:_____ (If no refills are specified rx is valid for 1 year.) |
| **Labs prior to first treatment** | ☐ Glucose-6-phosphate dehydrogenase (G6PD) deficiency. |
| **Labs prior to each treatment** | ☐ sUA ~ NOTIFY physician if 2 consecutive serum uric acid levels are over 6 mg/dL - sUA test, preferably within 48 hours of the infusion. |
| **Treatment** | Minimum 2-hours infusion via gravity feed, syringe-type pump, infusion pump and 1-hour post infusion observation time |
| **NaCl** | 250 mL Krystexxa can be infused in normal saline (0.9% NS) or half-normal saline (0.45% NS) |

** DO **NOT** ADMINISTER AS AN INTRAVENOUS PUSH OR BOLUS. USE ASEPTIC TECHNIQUE. **

**PREMEDICATIONS**

| CLASS | DRUG(S) | DOSING | TIMING IN RELATION TO INFUSION |
|---|---|---|---|
| IV corticosteroids *† | ☐ 80 mg methylprednisolone<br>☐ 200 mg hydrocortisone<br>☐ Other:_____ | Or dose determined by heathcare provider | Prior to each infusion |
| Antihistamines *† | ☐ 60 mg fexofenadine<br>☐ 50 mg diphenhydramine<br>☐ Other: _____ | Or dose determined by heathcare provider | Night before infusion, and/or can administer concomitantly with infusion |
| Oral analgesic *† | ☐ 1000 mg acetaminophen | Or dose determined by heathcare provider | Prior to each infusion |

**In the event of anaphylaxis or infusion reaction, the infusion should be slowed, or stopped and restarted at a slower rate, at the discretion of the physician**

**GOUT FLARE PROPHYLAXIS**

| CLASS | DRUG(S) | DOSING | TIMING IN RELATION TO INFUSION |
|---|---|---|---|
| Anti–gout flare agent | Colcrys® (colchicine) | Dose determined by healthcare provider<br>Patient may take any one of these drugs, as indicated | Daily, treatment initiated 1 week prior to initiation of Krystexxa and lasting at least 6 months, unless medically contraindicated or not tolerated |
| Oral NSAIDs | Advil®, Aleve® | | |
| Corticosteroids | Prednisone, prednisolone | | |

* To be given to the patient by nurse on the day of infusion.
† Infusion reaction may occur despite pretreatment.

Inform patients of the symptoms and signs of anaphylaxis and instruct them to seek immediate medical care should anaphylaxis occur after discharge from the healthcare setting.

**SIGNATURE**

x _____ Date: _____
Physician's Signature



**Fax completed form to: (800) 783-9146 - Thank you for using BioTek reMEDys®**