Krystexxa® Referral Form

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

PATIENT INFORMATION (Complete or fax existing chart)

Patient Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ 2nd Phone: _____
DOB: _____ Gender: ☐ Male ☐ Female
Weight: _____ Ht: _____
Allergies: _____

PRESCRIBER INORMATION

Prescriber Name: _____
State License: _____ NPI #: _____
DEA: _____ Phone: _____
Specialty: _____ Fax: _____
Address: _____
City, State, Zip: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION - OR - Send a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____ Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
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
Diluent	Krystexxa 8mg can be deluted in 250 mL of sodium chloride 0.9% or sodium chloride 0.45%
Co-administration medication	Is there an immunomodulator prescribed? Yes ☐ No ☐ ☐ If yes please indicate: ☐ Methotrexate ☐ Other

** 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 ☐ 200 mg hydrocortisone ☐ Other:_____	Or dose determined by heathcare provider	Prior to each infusion
Oral Antihistamines *†	☐ 60 mg fexofenadine ☐ 50 mg diphenhydramine ☐ 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 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: (888) 963-8103 - Thank you for using BioTek reMEDys®

☐ No ☐