

PATIENT INFORMATION (Complete or fax existing chart)	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	State License: _____ NPI #: _____
City, State, Zip: _____	DEA: _____ Phone: _____
Phone: _____ 2 <sup>nd</sup> Phone: _____	Specialty: _____ Fax: _____
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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	
<b>Dose / Schedule</b> 8 mg given as an intravenous infusion every 2 weeks	Refills: _____ (If no refills are specified rx is valid for 1 year.)
<b>Labs prior to first treatment</b>	<input type="checkbox"/> Glucose-6-phosphate dehydrogenase (G6PD) deficiency.
<b>Labs prior to each treatment</b>	<input type="checkbox"/> sUA - <b>NOTIFY</b> physician if 2 consecutive serum uric acid levels are over 6 mg/dL - sUA test, preferably within 48 hours of the infusion
<b>Treatment</b>	Minimum 2-hours infusion via gravity feed, syringe-type pump, infusion pump and 1-hour post infusion observation time
<b>Diluent</b>	Krystexxa 8mg can be deluted in 250 mL of sodium chloride 0.9% or sodium chloride 0.45%
<b>Co-administration medication</b>	Is there an immunomodulator prescribed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes please indicate: <input type="checkbox"/> Methotrexate <input type="checkbox"/> Other
<b>** DO NOT ADMINISTER AS AN INTRAVENOUS PUSH OR BOLUS. USE ASEPTIC TECHNIQUE. **</b>	

PREMEDICATIONS			
CLASS	DRUG(S)	DOSING	TIMING IN RELATION TO INFUSION
IV corticosteroids *†	<input type="checkbox"/> 80 mg methylprednisolone <input type="checkbox"/> 200 mg hydrocortisone <input type="checkbox"/> Other: _____	Or dose determined by healthcare provider	Prior to each infusion
Oral Antihistamines *†	<input type="checkbox"/> 60 mg fexofenadine <input type="checkbox"/> 50 mg diphenhydramine <input type="checkbox"/> Other: _____	Or dose determined by healthcare provider	Night before infusion, and/or can administer concomitantly with infusion
Oral analgesic *†	<input type="checkbox"/> 1000 mg acetaminophen	Or dose determined by healthcare 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 _____ Physician's Signature	Date: _____

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