Krystexxa Infusion Order

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Patient Phone: _____

Allergies: _____ Patient Insurance: _____

For us to complete the Prior Authorization, please attach patient demographics, insurance, medical history, labs, and progress notes.

Medical Information

☐ Chronic Gouty Arthropathy **with** tophus/tophi
☐ Chronic Gouty Arthropathy **without** tophus/tophi
ICD 10: _____

Dose Orders

REQUIRED PRE-TREATMENT MEDICATIONS

CORTICOSTEROID (30 minutes prior to infusion)
☐ Hydrocortisone: ☐ 200 mg IV or ☐ _____ mg IV
☐ Methylprednisone: _____ mg (40 -125 mg) IV
☐ Other: _____

ANTIHISTAMINE (night before and/or 30-60 minutes prior to infusion start)
☐ Diphenhydramine: ☐ 25 mg PO / IV or ☐ 50 mg PO / IV
☐ Fexofenadine: ☐ 60 mg PO or ☐ 180 mg PO
☐ Loratadine: ☐ 5 mg PO ☐ 10 mg PO
☐ Other: _____

ANALGESIC (night before and/or 30-60 minutes prior to infusion start)
☐ Acetaminophen: ☐ 650 mg or PO ☐ 1000 mg PO
☐ Other: _____

Krystexxa: ☐ 8mg IV in 250 mL 0.9% NS over 2-4 hours with a 1-hour observation time post-infusion
Frequency: ☐ Repeat dose every 2 weeks for 1 year ☐ Other: _____

Therapy Initiation Requirements

☐ Serum uric acid (sUA) 24-72 hrs. prior to infusions – patient aware.
☐ G6PD serum levels WNL and attached
☐ Methotrexate 15 mg PO weekly to begin >4 weeks prior to and throughout treatment
☐ Folic acid 1 mg PO daily to begin >4 weeks prior to and throughout treatment

REFERRING PROVIDER INFORMATION

PROVIDER NAME: _____ **SIGNATURE:** _____

DATE: _____ **PROVIDER NPI:** _____ **PHONE:** _____ **FAX:** _____

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