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:** _____

Active Infusions Phone: 240-200-4464 Fax: 240-892-3005 info@activeinfusions.com www.activeinfusions.com

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION