Local Infusion

MYLOCALINFUSION.COM

KRYSTEXXA (PEGLOTICASE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

❑ Chronic Gout, ICD 10: M1A._____

❑ Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI:_____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATIONS PER KRYSTEXXA PROTOCOL

IV corticosteroid:

❑ Hydrocortisone 200 mg

❑ Methylprednisolone 40 mg

❑ Methylprednisolone 125 mg

Antihistamine:

❑ ____ mg Diphenhydramine ❑ PO ❑ IVP

❑ ____ mg Fexofenadine PO

❑ ____ mg Loratadine PO

Analgesic:

❑ 1000 mg Acetaminophen PO

❑ Other: _____

❑ Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Krystexxa	❑ 8 mg	❑ IV	❑ Every 2 weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❒ CT: 203.433.0621 ❒ MD: 240.224.8607 ❒ ME: 207.407.7272 ❒ NH: 603.217.5371
❒ NJ: 201.581.4521 ❒ VA: 703.202.0499

Order valid for 1 year from date of signature unless otherwise specified here: _____