DELIVERIT PHARMACY
Infusion & Specialty

KRYSTEXXA (PEGLOTICASE) Infusion Orders

T: 832.939.8137 Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478 F: 832.939.8128

Patient Name: _____ Social Sec #: _____ Weight: ____ lbs

D.O.B: _____ Sex: Male ____ Female _____ Height: ____ lbs

Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

JCode: J2501 Diagnosis

☐ Chronic Gouty Arthropathy w/tophus (tophi) (ICD-10 Code:_____

☐ Chronic Arthropathy w/o mention of tophus (tophi) (ICD-10 Code:_____

Allergies: _____ Date of last infusion: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

☐ Krystexxa service request form

☐ Baseline Uric Acid Level _____ Date of last Uric Acid Level Needed_____

☐ Normal Glucose-6-phoshate dehydrogenase (G6PD) attached

☐ It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa

☐ Documentation of frequency and date of flares in last 18 months:

_____

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

KRYSTEXXA ORDERS

KRYSTEXXA ☐ Dose: 8mg IV in 250 ml of NS IV over 120 minutes

Patient will be observed 1 hour post infusion

Frequency: Every 2 weeks

Protocol Pre-Medication Orders: Solu-Medrol _____mg IV, Benadryl _____mg PO/IV, Cetirizine 10mg,

Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

Patient will be advised to take antihistamine day before infusion

***Patient must have Uric Acid level drawn 24-72 hours prior to each infusion**

***Patient must have a be negative after a Glucose-6-phosphate dehydrogenase (G6PD) deficiency screening prior to initiating therapy**

***Additional Orders/Comments:**

Hypersensitivity/Anaphylaxis Response Protocol PRN

PHYSICIAN INFORMATION

By signing this form and utilizing ur services, you are authorizing DeliverIt Pharmacy and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____