Krystexxa® Referral Form

PHONE: 1-800-277-7302 FAX: 1-866-374-6663 Email: intake@healthcoga.com ☐ ***Initial Order*** ☐ ***Reorder***

Demographics Information: Today's Date ___________________

Patient Name: ____ DOB: ___________________________

Address: ____ City: __________________ State: GA Zip: _________

Phone #: ______________________________ ☐ Cell Alternate Phone #: ___________________________ ☐ Cell

Height:______ in/ft Weight: ________ lbs/kg Date weight recorded: _________ Last 4 of SSN: ____________

Allergies: ____ ☐ **NKDA**

Diagnosis Information: ☐ M1A.9XX0 Chronic Gout, unspecified site, without mention of tophus(tophi)
☐ M1A.9XX1 Chronic Gout, unspecified site, with mention of tophus(tophi)
☐ Other Diagnosis/ICD10Code_______________________________________

Date Infusion to Begin: _________________________

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _________________________________

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: ______________________________

List of Failed Therapies: ____________________________

Please Provide Appropriate Documentation:
List of failed therapies: ☐ Allopurinol ☐ Colchicine ☐ Uloric Acid ☐ Probenicide ☐ Probenicide/Colchicine

Baseline SUA level: _______ **Date obtained:** __________ **G6PD test results**: _________________________

Krystexxa® (Pegloticase): J2507 **Is patient also on an immunomodulator? ☐ Yes ☐ No**
If No, please explain why: ____

☐ SUA level drawn preferably within 48hrs prior to infusion; 8 mg IV infused over 2 hours every 2 weeks for ________months: ***Nurse to Administer Methylprednisolone 100mg IV x1 dose 30 minutes prior to infusion***
☐ **Verify Gout flare prophylaxis**: ____

Pre-Medications: Patient to Provide and take 30 minutes prior to infusion

☐ Benadryl 25 MG PO x1 ☐ Benadryl 50 mg PO x1
☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1
☐ Other Pre-medication: ______________________________________

Access: ☐**PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5ml: Qty 4

PORT – NS 10ml: Qty 4, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10ml: Qty 4, Heparin 5mL 10units/mL x 1 per infusion

Supplies: (please strike through if not required)

Administration Supplies (A4222) – 2 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer medications

Administer the anaphylaxis protocol for adverse reactions

Provider signature: ____

NPI # ____________________________ Phone ________________________ Fax _________________________

Office Address: ___________________________________ City: ____________________ St____Zip: _________

Printed MD Name: ________________________________ Contact Name: ______________________________

☐ Demographic information ☐ Patient Ins. Card ☐ H & P ☐ Office notes ☐ Failed therapies in documentation
☐ Up to date medication list

9/23 TSP