Krystexxa® Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: ______ Ship To: Home Office Other: ______

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ______	Prescriber Name: ______
Address: ______	Address: ______
City, State, Zip: ______	City, State, Zip: ______
Home Phone: ______	Phone: ______
Cell Phone: ______	Fax: ______
Date of Birth: ______ Gender: ______	DEA #: ______ NPI #: ______
Emergency Contact: ______ Phone: ______	Contact Person: ______

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: ______ ID: ______ Group: ______
Secondary Insurance: ______ ID: ______ Group: ______
Prescription Card: ______ ID: ______ BIN: ______ PCN: ______

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

M1A.9XX0 Chronic gout, unspecified, without tophus (tophi)
Other: ______

Tested for G6PD deficiency Date of negative test result: ______
Tested for serum uric acid levels Result: ______
Patient is currently on immunomodulators Yes No
methotrexate Other: ______
Lab Orders: ______
Please send anaphylaxis kit as per protocol

Patient Weight: ______ kg lbs Height: ______ cm in
Allergies: ______
Line Access: Peripheral Port
Delivery Method: Infusion Pump Other: ______
Therapy Start Date: ______ Therapy End Date: ______
Nursing Coordination:
Pharmacy to coordinate home health nursing visit as necessary: Yes No
Home health nursing coordination not necessary. Reason:
MD office to administer to patient
Home health nursing already coordinated

PRESCRIPTION INFORMATION

Krystexxa® (pegloticase) Prescription:

Dose/Strength:	Directions:	Quantity:	Refills:
8mg/ml (1ml) vial	Infuse 8mg intravenously over at least 2 hours every 2 weeks		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol

Peripheral:
NaCl 0.9% 5mL
NaCl 0.9% 10mL

Implanted Port:
NaCl 0.9% 5 to 10mL pre-/post-use and 10 to 20mL pre-/post-lab draw
Heparin (100 unit/mL) 3 to 5 mL post-use
For maintenance, heparin (100 unit/mL) 3 to 5mL every 24 hr if accessed or weekly to monthly if not accessed

Other: ______

Premedications & Other Medications
Infusion supplies as per protocol
Has anaphylaxis kit available as per protocol
Acetaminophen 650 mg PO prior to infusion
Diphenhydramine 25 mg PO
Solu-Medrol® ______ IV x 1 dose prior to infusion

ADDITIONAL COMMENTS:

Prescriber Signature: ______ **Date:** ______

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