InfuCare Rx®

Krystexxa® Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

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

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
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: _____

Lab Orders:

- STAT serum uric acid (sUA) levels to be drawn at least 48 hours prior to each scheduled infusion.

☐ Other: _____

Lab Monitoring Parameters:

- If sUA level > 6mg/dL, pharmacist will call physician to report the **lst elevated sUA level** and continue with the scheduled infusion if **no prior instances** of infusion related reactions, unless physician gives an order to hold or discontinue therapy.
- If sUA level > 6mg/dL for **2nd consecutive time**, pharmacist will call physician to get an order to discontinue therapy and discharge patient from InfuCare Rx Services.

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: _____
Therapy Start Date: _____ Therapy End Date: _____

Patient is currently on immunomodulators ☐ Yes ☐ No
☐ methotrexate ☐ Other: _____
☐ Please send anaphylaxis kit as per protocol

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

Prescription:

Dose/Strength:	Directions:	Quantity:	Refills:
☐ Krystexxa® (pegloticase) 8 mg/50 ml RTU vial	☐ Infuse 8mg intravenously over at least 2 hours every 2 weeks		
☐ Colchicine 0.6mg tablet	☐ Take 1 tablet by mouth once daily for Gout flare prophylaxis. Start at least 1 week prior to initiating Krystexxa infusions and lasting at least 6 months. ☐ Take 1 tablet by mouth twice daily for Gout flare prophylaxis. Start at least 1 week prior to initiating Krystexxa infusions and lasting at least 6 months. ☐ _____		

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
☐ Other: _____
☐ Heparin (100 unit/mL) 3 to 5mL post-use
☐ For maintenance, heparin (100 unit/mL) 3 to 5mL every 24 hr if accessed or weekly to monthly if not accessed

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

Prescriber Signature: _____ **Date:** _____

Revised 01 Apr 2026