Krystexxa

INFUSE ONE OHIO

Pegloticase

Treatment Location: ☐ Dublin, OH ☐ Lancaster, OH

PROVIDERS: Please include the following to expedite the order: Patient Demographics, Most Recent Office Visit Notes, Medication List, Insurance Information, Labs: Baseline Serum Uric Acid and Screening for G6PD Deficiency

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ M1A.0 ____ ☐ M1A.3 ____ ☐ M1A.4 ____ ☐ M1A.9 ____ ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infuse One Ohio

☑ Is there an immunomodulator prescribed? ☐ Yes ☐ No
If yes, please indicate below:

☐ Methotrexate ☐ Other: _____

It is recommended to start methotrexate with folic acid or folinic acid supplementation at least 4 weeks prior to initiating and throughout treatment.

☑ Have oral urate-lowering medications been discontinued?
☐ Yes ☐ No

It is recommended to discontinue all oral urate-lowering medications prior to starting Krystexxa treatment and not institute therapy with oral urate-lowering medications while patients are currently on Krystexxa therapy.

☑ G6PD Enzyme Activity Level _____

☑ Baseline Serum Uric Acid Level _____

PRE-MEDICATION ORDERS

It is recommended to premedicate with antihistamines and corticosteroids prior to infusion.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Methylprednisolone ☐ 40mg / ☐ 125mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

☑ Krystexxa Intravenous Infusion

Dose: 8mg

Frequency: ☐ Every 2 weeks ☐ Other: _____

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS:

Provider Name (Print) Provider Signature Date

☐ ***Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***