Provider Order Form

KRYSTEXXA (PEGLOTICASE)

Uptiv Health

PATIENT

Full Name: ______________________ DOB: ______________

Mobile Phone: ______________________ Weight: ________ ☐ lbs ☐ kg

Allergies: ______________________ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: ____________ Next Treatment Date: ________

DIAGNOSIS ICD-10 code (must be specified)

☐ Chronic Gout M1A ______________________ ☐ Other: ______________________

PROVIDER

Provider Name: ______________________ Provider NPI: ______________________

Practice Name: ______________________ Referral Coordinator Name: ______________________

Practice Address: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO	☐ 500 mg	☐ 650 mg	☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV	☐ 25 mg	☐ 50 mg	
☐ Methylprednisolone (Solu-Medrol) IV	☐ 40 mg	☐ 125 mg	
☐ Cetrizine (Zyrtec) 10 mg PO			

☐ Other: ______________________

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☒ Krystexxa(Pegloticase), IV in 250ml 0.9% sodium chloride	☐ 8 mg	☐ Every 2 weeks

☐ Patient will be on methotrexate or other immunomodulation therapy.

Product information suggests co-administration of 15 mg weekly of methotrexate and folic acid therapy if not contraindicated. If co-administering methotrexate, start weekly methotrexate and folic acid or folinic acid supplementation at least 4 weeks prior to initiation, and throughout treatment with Krystexxa.

Refills ☐ Zero ☐ 12 months ☐ ____________. Order valid for 1 year unless otherwise stated. ________________

☒ Infuse over 120 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every ________
☐ CMP	☐ at each dose	☐ every ________
☐ CRP	☐ at each dose	☐ every ________
☐ URIC ACID PRIOR TO EACH INFUSION		
☐ Other ______________		

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ Glucose-6-phosphate dehydrogenase (G6PD)

☐ Baseline Serum Uric Acid level

______________________ ______________________

Provider Signature Date