

Krystexxa[®] Order Form

Fax Completed Form To:

Phone:



PATIENT INFORMATION			
Patient Name:	Date of Birth:	Referral Date:	
Address:		City/State/Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	Male Female
Patient Diagnosis & ICD-10:			
Allergies:			

PROVIDER INFORMATION		
Physician Name:	Lic.#:	DEA #:
Practice Name:		NPI#:
Address:		City/State/Zip:
Office Contact:	Phone:	Fax:
Supervisory Physician (if applicable):		

PLEASE ATTACH	
Patient demographics & front/back copy of all insurance cards (prescription & medical) Recent office visit notes, history & physical, lab & pertinent procedure results Current medication list & list of prior medications tried and failed (with dates) G6PD deficiency results Verification that patient has discontinued or plans to discontinue oral urate lowering medications	Evidence of patient on concurrent immunomodulation therapy such as: methotrexate, mycophenolate, leflunomide, azathioprine, or cyclosporine (Evidence supports the combination of Krystexxa and an immunomodulator in improving the patient's response to therapy; consider adding an immunomodulator if clinically appropriate.) Baseline serum Uric Acid lab results Letter of medical necessity if drug dosing or indication is outside of FDA guidelines

NURSING & LAB ORDERS
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - 10units/mL ---OR--- 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:

PRESCRIPTION ORDERS			
Anaphylaxis Kit:	Epinephrine 0.3mg IM as needed	Solu-cortef 250mg-500mg IV infusion as needed	Solu-Medrol 60mg - 125mg IV infusion as needed
(Check all that apply)	Diphenhydramine _____ mg IV infusion as needed	NS Hydration 500 ml IV infusion over 30 minutes as needed	Other _____
Pre-Medications:	Per prescribing information: Pre-medications of antihistamine, corticosteroid and analgesic is recommended		
(Check all that apply)	Acetaminophen _____ mg PO _____ minutes prior to infusion	Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion	
	Diphenhydramine _____ mg PO ---OR--- IV infusion _____ minutes prior to infusion	Other _____	

Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary

PRODUCT	PRESCRIPTION INFORMATION	REFILLS
Is this a first dose? Yes No	If No, when was last dose given? _____ When is patient due for next dose? _____	
Krystexxa	8mg IV infusion via gravity or pump over at least 2 hours every 2 weeks <input checked="" type="checkbox"/> After first infusion, patient to have sUA level performed within 48 hours prior to each infusion. For KVO: NS 100mL via IV infusion over 1 hour. If sUA is ≤ 6mg/dL, proceed. If sUA is > 6mg/dL, hold & contact provider.	_____
OTHER		_____

By signing this form and utilizing our services, you are authorizing Amerita to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____
 Dispense as Written _____
 Print Name _____
 Date _____

Prescriber's Signature _____
 Substitution Permitted _____
 Print Name _____
 Date _____

