

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:	<input type="checkbox"/> Male <input type="checkbox"/> 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	
<input type="checkbox"/> Patient demographics & front/back copy of all insurance cards (prescription & medical) <input type="checkbox"/> Recent office visit notes, history & physical, lab & pertinent procedure results <input type="checkbox"/> Current medication list & list of prior medications tried and failed (with dates) <input type="checkbox"/> G6PD deficiency results <input type="checkbox"/> Verification that patient has discontinued or plans to discontinue oral urate lowering medications	<input type="checkbox"/> 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.) <input type="checkbox"/> Baseline serum Uric Acid lab results <input type="checkbox"/> 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 - <input type="checkbox"/> 10units/mL ---OR--- <input type="checkbox"/> 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:

PRESCRIPTION ORDERS
Anaphylaxis Kit: <input type="checkbox"/> Epinephrine 0.3mg IM as needed <input type="checkbox"/> Solu-cortef 250mg-500mg IV infusion as needed <input type="checkbox"/> Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) <input type="checkbox"/> Diphenhydramine _____ mg IV infusion as needed <input type="checkbox"/> NS Hydration 500 ml IV infusion over 30 minutes as needed <input type="checkbox"/> Other
Pre-Medications: Per prescribing information: Pre-medications of antihistamine, corticosteroid and analgesic is recommended (Check all that apply) <input type="checkbox"/> Acetaminophen _____mg PO _____minutes prior to infusion <input type="checkbox"/> Solu-Medrol _____mg IV infusion _____minutes prior to infusion <input type="checkbox"/> Diphenhydramine _____mg <input type="checkbox"/> PO ---OR--- <input type="checkbox"/> IV infusion _____minutes prior to infusion <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was last dose given? _____ When is patient due for next dose? _____		
<input type="checkbox"/> Krystexxa	<input type="checkbox"/> 8mg IV infusion via <input type="checkbox"/> gravity ---OR--- <input type="checkbox"/> pump over at least 2 hours every 2 weeks <input 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.	_____
<input type="checkbox"/> 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

