PARAGON HEALTHCARE

A Carelon Company

KRYSTEXXA (PEGLOTICASE) INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Chronic Gouty Arthropathy w/tophus (tophi)
☐ Chronic Arthopathy w/o mention of tophus (tophi)
☐ Other: _____

ICD-10 Code: _____

Weight: _____ lbs Allergies: _____

THERAPY ORDER

Krystexxa Dose: 8mg IV in 250mL of NS IV over 120 minutes
*Patient will be observed 1 hour post infusion

Frequency: Every 2 weeks

Refills: ☐ 1 year ☐ Other: _____

If you would like Paragon to dispense the methotrexate, please check appropriate box:
☐ Methotrexate 15mg PO weekly x1 year (to begin 4 weeks prior to Krystexxa)

Protocol Pre-Medication Orders: Solu-Medrol 125mg IV, Benadryl 25mg PO/IV
**Patient advised to take antihistamine day before infusion*

Lab Orders: Serum uric acid 24-72 hours prior to infusion
☐ G6PD serum level (required prior to first dose)
☐ Other lab orders: _____

Labs: Required labs to be drawn by ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR KRYSTEXXA (PEGLOTICASE) THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Krystexxa Service Request form
- ☐ Supporting clinical notes (H&P) to support primary diagnosis

Product information suggests the co-administration of weekly oral methotrexate 15mg and folic acid or folinic acid supplementation. Krystexxa alone may be used in patients where methotrexate is contraindicated or not clinically appropriate. If co-administering with methotrexate, start weekly methotrexate and folic or folinic acid supplementation at least 4 weeks prior to initiating, and throughout treatment with Krystexxa

- ☐ Will the patient co-administer methotrexate or other immunomodulation therapy?
  - ☐ Yes ☐ No If yes, which drug? _____
- ☐ Documentation of frequency and date of flares in the last 18 months (either attach or document here): _____
- ☐ Has the patient tried and failed Allopurinol/Uloric, Colchicine, or Probenecid?
  - ☐ Yes ☐ No If yes, which drug(s)? _____

- ☐ Labs attached, including:
  - ☐ Baseline serum uric acid (**required**)
  - ☐ G6PD serum level (**required**)
- ☐ It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance