



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

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				

Diagnosis Code ICD-10: (required)	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:		Email:	
Address:		City:	State: ZIP:
NPI #:	DEA#:	Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Medication Orders	Refills
Krystexxa <input type="checkbox"/> 8mg IV over 120 minutes *Patient will be observed 1 hour post infusion Frequency: Every 2 weeks Protocol Pre-Medication Orders: Solu-Medrol 125mg IV, Benadryl 25mg PO/IV	<input type="checkbox"/> 1 year <input type="checkbox"/> Other: _____

Other orders: _____

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

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.	<input type="checkbox"/> Dispense as written
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PRESCRIBER SIGNATURE 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.

Prescriber Signature: X	Date:
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PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & INSURANCE APPROVAL

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

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
- Prescriber- please enroll patient in the manufacturer HUB program