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

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ 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)

Drug	Dosing	Refills
Krystexxa (pegloticase)	☐ 8mg IV every 2 weeks ☐ Other: _____	☐ 1 year ☐ _____

Pre-Medication Orders: Solu-Medrol 125mg IV, diphenhydramine 25mg PO/IV (if no contraindications)
Other pre-medication orders: _____

Other orders: _____

Lab Orders: Serum uric acid 24-72 hours prior to infusion
☐ G6PD serum level (required prior to first dose)
☐ Other lab orders: _____
Required labs to be drawn by ☐ Infusion Center ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

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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COMPREHENSIVE SUPPORT FOR KRYSTEXXA (PEGLOTICASE) THERAPY

PATIENT INFORMATION

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 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