

Physician Infusions Krystexxa Referral Form

Patient Information

Patient Name:	DOB:
Address:	
Phone:	Email:
Allergies:	

Insurance Information (Include a copy of the front and back of patient's insurance card)

Primary:	Policy #:	Group #:	Ins Phone:
Secondary:	Policy #:	Group #:	Ins Phone:

Referring Provider Office Information

Provider Name:	NPI:	Office Name:	
Office Address:			
Office Contact:	Phone:	Fax:	Email:

Pre-medications

☐	Physician Infusions to order pre-medications per standard infusion protocols/procedures		
-- OR --			
☐	_____ mg Acetaminophen PO	☐	_____ mg Diphenhydramine PO
☐	_____ mg Cetirizine PO	☐	_____ mg Diphenhydramine IV
☐	_____ Other IV/PO	☐	_____ mg Solumedrol IV

Required Labs

☐	Physician Infusions to order baseline labs/G6PD/uric acid monitoring (G6PD screening must be negative prior to initiation)
-- OR --	
☐	CBC, CMP, Quantiferon TB, Uric acid, G6PD
☐	Laboratory Frequency:
☒ Serum Uric Acid (sUA) drawn within 48 hours prior to each infusion.	

Diagnosis

☐ M1A.9XX0 Chronic Gout w/o tophus	☐ M1A.9XX1 Chronic Gout with tophus
---	--

Prescription

Medication: Krystexxa (pegloticase) Dose: 8 mg in 250 mL 0.9% Sodium Chloride IV over at least 120 minutes every 2 weeks.			
Route: IV	Refills: 11	First Infusion? Y/N	Last Infusion Date (If applicable):
☐	Titrate duration of Krystexxa to resolution of tophi and gout flares according to protocol		
☐	Defer management of immunomodulatory agents and gout flare management to referring physician		
☒ Hold infusion and notify prescriber if 2 consecutive sUA levels are > 6 mg/dL.			
☒ Provide nursing care per Physician Infusions policies and procedures, including but not limited to post-infusion observation and management of adverse reactions.			

Special Instructions

--

Please send this completed form, office notes, labs/imaging results to Physician Infusions fax (512) 354-4938.

Prescriber Signature: _____ Prescriber Printed Name: _____ Date: _____