



Krystexxa (pegloticase)

New Referral Continuing Treatment Medication Order Change

Patient Information:

Name: _____
 Date: _____
 DOB: _____
 SS#: _____
 Phone #: _____
 Email: _____

Physician Information:

Referring Physician: _____
 Address: _____

 Phone #: _____
 Fax #: _____

Medication Orders

Patient Weight: _____ kg Patient Height: _____ inches

First Dose Maintenance Dose

Dosing: **8mg IV every 2 weeks for 6 months**

Premeds: Benadryl 25mg IV Tylenol 1000mg PO Dexamethasone 20mg IV _____

Indication / Diagnosis:

M1A.9xx1 Chronic gout, unspecified, with tophus (tophi)

Other (please specify) _____

ICD-10 (Required) _____

MD Signature: _____ NPI#: _____ Date: _____

****HAS PATIENT BEEN ON MTX FOR 2 WEEKS: YES or NO****

****Patient will have 1 hour observation post-infusion prior to D/C****

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- Uric Acid
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- G6PD

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