ARJ Infusion SERVICES

Specialty Pharmacy and Nursing

FAX completed form to ARJ 877-451-8955
Intake Specialist 866-451-8804
referral@arjinfusion.com
arjinfusion.com/referrals

Krystexxa (pegloticase) I Order Form

Patient Name: _____ DOB: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

1. For new patients, please submit with form:

☒ Copy of insurance card ☒ Patient demographics ☒ History & physical ☒ Pertinent lab results

2. Patient Information

☐ Male ☐ Female Height: _____ in/cm Weight: _____ lbs/kg Allergies: _____

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

3. Diagnosis and Clinical Information

Primary diagnosis information: ☐ Gout ☐ Other: _____ ICD-10 (required): _____

G6PD deficiency is a contraindication to Krystexxa, has patient been screened and, if high risk, tested for G6PD deficiency?

☐ Yes, patient screened and not at high risk. Patient will not be tested for G6PD deficiency

☐ Yes, patient screened and is at high risk. Please provide test results: _____ (a negative result means patient does not have G6PD deficiency)

(Note: Higher risk patients may include, but not are not limited to, patients of African, Mediterranean, Southern European, Middle Eastern, and South Asian ancestry, and African-Americans; prescriber to assess risk and need for testing)

Baseline serum uric acid level (must be >6.0mg/dL to initiate Krystexxa): _____mg/dL

- Uric acid levels are required to be drawn 1 to 2 days prior to each infusion, referring provider to arrange lab draws locally
  Name of lab facility: _____ Phone number for lab results: _____
- Please fax results to ARJ at 877-451-8955 as soon as available
- A single uric acid of >6.0mg/dL will require follow-up with provider, but will not post-pone next infusion

4. Prescription Information

Medication	☒ **Krystexxa** (pegloticase)
Dosing / Frequency	☒ 8mg in 250mL sodium chloride 0.9% IV every 2 weeks
Administration	☒ Prepare and infuse per manufacturer guidelines. Infuse over no less than 2 hours and observe patient for 1 hour following infusion ☒ May infuse in patient home unless otherwise noted: _____
Quantity / Refills	Dispense 2-week supply on all selected medications Refill x 12 months unless otherwise specified: _____

5. Additional Orders

☒ RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure

☒ **Give standard premedications 30 minutes prior to infusion:**

☒ Methylprednisolone 125mg **OR** _____ mg IV

☒ Antihistamine (may take night prior or concomitantly with infusion, pharmacist to select product if none checked):

☐ Diphenhydramine 25mg PO ☐ Cetirizine 10mg PO ☐ Fexofenadine 180mg PO ☐ Loratadine 10mg PO

☒ Acetaminophen 325-650mg **OR** _____ mg PO

☐ Other: _____

☒ RN to instruct patient to hydrate pre/post infusion. RN to instruct patient to take diphenhydramine 25-50 mg PO and acetaminophen 325-650 mg PO every 4-6 hours for 24-48 hours as needed to prevent/treat post infusion headache

6. Adverse Reaction Orders

In the event of an infusion reaction (i.e.: fever, chills, backache, headache) the following orders will be followed, and the physician will be notified. *Note: For mild reactions, patient may be treated, and infusion resumed at a slower rate*

☒ **STOP** infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping the infusion does not resolve symptoms:

☒ Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 min **OR** 50 mg/10 mL NS IV push over 2-3 min

☒ Methylprednisolone 125 mg (**OR** _____ mg) slow IV push over 5 minutes

☒ Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used

7. Prescriber Information

Prescriber Name: _____ Office Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ License No.: _____

DEA No.: _____ NPI: _____

_____ _____ _____ _____

Physician Signature (Substitution Permitted) Date **Physician Signature (Dispense as Written)** Date

By signing I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.