

Krystexxa® Order Form

Fax Completed Form To:

Phone:

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		City/State/Zip:	
Home Phone:		Cell Phone:	
Secondary Contact:		Work Phone:	
Patient Diagnosis & ICD-10:		Height: Weight: ☐ Male ☐ Female	
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
Office Contact:		City/State/Zip:	
Phone:		Fax:	
Supervisory Physician (if applicable):			
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical) ☐ Recent office visit notes, history & physical, lab & pertinent procedure results ☐ Current medication list & list of prior medications tried and failed (with dates) ☐ G6PD deficiency results ☐ Verification that patient has discontinued or plans to discontinue oral urate lowering medications		☐ Evidence of patient on concurrent immunomodulation therapy such as: methotrexate, mycophenolate, leflunomide, azathioprine, or cyclosporine (Evidence supports the combination of Krystexxa and an immunomodulator in improving the patient's response to therapy; consider adding an immunomodulator if clinically appropriate.) ☐ Baseline serum Uric Acid lab results ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines	
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders. Flush Orders: NaCl 0.9% - 5-10mL flush pre and post infusion and as needed Heparin - ☐ 10units/mL ---OR--- ☐ 100units/mL - 3-5mL flush after post-infusion NS flush if indicated to maintain line Lab Orders: Lab Date & Frequency:			
PRESCRIPTION ORDERS			
Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 60mg - 125mg IV infusion as needed (Check all that apply) ☐ Diphenhydramine _____ mg IV infusion as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other			
Pre-Medications: Per prescribing information: Pre-medications of antihistamine, corticosteroid and analgesic is recommended (Check all that apply) ☐ Acetaminophen _____ mg PO _____ minutes prior to infusion ☐ Solu-Medrol _____ mg IV infusion _____ minutes prior to infusion ☐ Diphenhydramine _____ mg ☐ PO ---OR--- ☐ IV infusion _____ minutes prior to infusion ☐ Other			
Supply Orders: All supplies for vascular access line care, drug administration kit(s), pump, and IV pole will be provided as necessary			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____			
☐ Krystexxa	☐ 8mg IV infusion via ☐ gravity ---OR--- ☐ pump over at least 2 hours every 2 weeks ☐ After first infusion, patient to have sUA level performed within 48 hours prior to each infusion. For KVO: NS 100mL via IV infusion over 1 hour. If sUA is ≤ 6mg/dL, proceed. If sUA is > 6mg/dL, hold & contact provider.		_____
☐ OTHER			_____
<i>By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.</i>			

Prescriber's Signature	Print Name	Date	Prescriber's Signature	Print Name	Date
Dispense as Written			Substitution Permitted		