

Krystexxa (pegloticase)

Provider Order Form rev. 5/20/2022



www.aleracare.com

ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

| | | | | |
|------------------------|----------------|--------------------|----------------|--------------------------------|
| Patient Name: | | DOB: | | |
| Patient Phone: | | Patient Email: | | |
| NKDA | Allergies: | Weight lbs/kg: | Height: | |
| Patient Status: | New to Therapy | Continuing Therapy | Therapy Change | Next Due Date (if applicable): |

PROVIDER INFORMATION

| | | | |
|----------------------------|--|-----------------------------|------------------|
| Referral Coordinator Name: | | Referral Coordinator Email: | |
| Ordering Provider: | | Provider NPI: | |
| Referring Practice Name: | | Phone: | Fax: |
| Practice Address: | | City: | State: Zip Code: |

DOCUMENTATION (REQUIRED)

| | | | |
|------|---------------------------------|---------------------|------------------------|
| Labs | Insurance Card (front and back) | Current Medications | History/Progress Notes |
|------|---------------------------------|---------------------|------------------------|

ICD-10 CODE

M1A.9XX0 Chronic Gout

Other: _____

PRE-MEDICATION ORDERS

diphenhydramine (Benadryl) 25mg 50mg / PO IV IV
methylprednisolone (Solu-Medrol) 40mgIV 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV 200mgIV

ADDITIONAL PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
Other: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Krystexxa (pegloticase)

Dose: 8mg IV

Frequency: every 2 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) _____ Provider Signature _____ Date _____

Check here if this is a stat order