aleracare
advanced infusion centers™

FAX 833.329.4738

Krystexxa (pegloticase)

Provider Order Form rev. 8/22/2023

Patient Information

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ M1A.9XX0 Chronic Gout ◯ Other: _____

Medication Order

Krystexxa (pegloticase) **Dose:** ◯ 8mg IV **Frequency:** ◯ every 2 weeks

◯ Patient is currently taking an immunomodulator (i.e. methotrexate) Date Immunomodulator started: _____

Note: Immunomodulator therapy, such as methotrexate, has been shown to improve the patient's response to Krystexxa. It is recommended to begin this therapy at least 4 weeks prior to initiating Krystexxa

◯ Patient is not a candidate for immunomodulators

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs (G6PD, serum Uric Acid within 48 hours of each dose)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Pre-Medication Order

diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg / ◯ PO ◯ IV

methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

hydrocortisone (Solu-Cortef) ◯ 100mg IV

Addition Pre-Medication Orders

acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

cetirizine (Zyrtec) ◯ 10mg PO

loratadine (Claritin) ◯ 10mg PO

Other: _____

Dose:_____ Route: _____ Frequency: _____

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name Provider Signature Date

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order ◯

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Patient Information

Patient Name: DOB: Sex: ◯ M ◯ F Fasting: ◯ Y ◯ N

Patient Home Phone: Patient Cell Phone:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

Lab Test (Please circle or write in ICD-10)

◯ ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	◯ IgE	J45.4, J45.3, L50.9, J45.40, J45.50
◯ AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	◯ IgG	G35, G36.0
◯ HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	◯ IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
◯ BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	◯ IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
◯ CALCIUM	M81.0, M81.8	◯ IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
◯ CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	◯ LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
◯ CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	◯ MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
◯ COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	◯ PSA	R97.20, C61, N40.1, Z12.5, N40.0
◯ CREATININE	M81.0, M81.8, G35	◯ PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
◯ C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	◯ TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
◯ FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	◯ QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
◯ G6PD	M1A.9XX0, M1A.9XX1	◯ TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
◯ GROWTH HORMONE	E22, C7A.1, E34	◯ URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
◯ HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	◯ VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
◯ HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	◯ VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
◯ HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	◯ Miscellaneous Labs Not Listed (Write In)	

Frequency

◯ Prior to each dose ◯ Yearly ◯ Other: Please Specify Below

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Provider Name

Provider Signature

Date

Provider Phone