Krystexxa Prescription Order Form

Fax: 877.265.9119
Phone: 800.540.4700

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ Anticipated Start Date: _____

PATIENT INFORMATION

Last Name: _____
First Name: _____
SSN: _____ Date of Birth: _____
Gender: ☐ M ☐ F Height: _____ Weight: _____ ☐ lbs ☐ kg
Allergies: _____
Home #: _____ Alt #: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Guardian/Caregiver: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
☐ MD ☐ DO ☐ NP ☐ PA
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
License #: _____ NPI: _____ DEA#: _____
Phone: _____ Fax: _____
Contact Name: _____ Phone: _____
Collaborating Physician: _____

Please fax FRONT and BACK copy of ALL insurance cards (Prescription and Medical), most recent H&P, clinical assessment notes, and current medication list

PRIMARY DIAGNOSIS

☐ M1A Chronic Gout ☐ Other: _____

PRE-TREATMENT ORDERS

☐ Tylenol 1GM PO prior to infusion
☐ Benadryl 50MG IVP prior to infusion
☐ Solumedrol 100MG IVP prior to infusion
☐ Other: _____

THERAPY ORDERS

☐ Krystexxa 8mg in normal saline 250ml IV at 125ml/hr or slower every 2 weeks for ____ infusions. QTY: Quantity Sufficient (QS)

☐ Immune Modulator:

Start at least 2 weeks prior to Krystexxa infusion (please indicate below):

☐ Cellcept – Dose: _____SIG: _____ QTY: _____ RF: _____

☐ Other: _____SIG: _____ QTY: _____ RF: _____

OR

Start at least 4 weeks prior to Krystexxa infusion (please indicate below):

☐ Methotrexate – Dose: _____SIG: _____ QTY: _____ RF: _____
+ Folic Acid – Take 1mg PO Daily QTY: 30 RF: 11

☐ Gout flare prophylaxis: start at least 1 week prior to Krystexxa infusion (please indicate below):

☐ Colchicine – Dose: _____SIG: _____ QTY: _____ RF: _____

OR

☐ NSAID – Medication and Dose: _____ SIG: _____ QTY: _____ RF: _____

☐ Other: _____SIG: _____ QTY: _____ RF: _____

CrCl: _____

Dialysis Patient:
☐ Yes ☐ No

****Dose adjustment may be necessary****

☐ Lab Orders: Uric Acid every 2 weeks prior to Krystexxa infusion. If lab result is not available prior to infusion, RN to perform fingerstick via Uric Acid monitor
☐ Dispense Uric Acid monitor if needed

☐ Other Orders: _____

☐ Dispense anaphylaxis kit PRN for infusion reaction will contain the following (1 each):

- ✓ Diphenhydramine 25mg cap
- ✓ Diphenhydramine 50mg/ml
- ✓ Solumedrol 125mg vial
- ✓ 0.9% NaCL 500ml bag
- ✓ 0.9% NaCL 500ml bag
- ✓ Zofran 4mg vial IVP
- ✓ Epinephrine pen: Inject IM/SQ into outer thigh PRN allergic reaction, including anaphylaxis

- Skilled Nursing visits needed to establish venous access, administer medication and assess general status and response to therapy.
- Infusion to be administered by pump or regulated dial a flow
- Supplies are necessary to administer therapy

Infusion reaction: Per Polaris Patient Infusion Reaction policy
Access: ☐ Peripheral ☐ PICC ☐ Port ☐ Other: _____
Flushing: Polaris Pharmacy Guideline (heparin 10-100u/ml, 0.9% NaCL and/or D5W flushes PRN to establish and maintain IV access)

PRESCRIBER SIGNATURE

(Prescriber, please date and below)

No stamps. Signature and date must be completed in prescriber's handwriting.
NY prescriptions must be submitted via e-script.

Prescriber Signature – Substitution Permissible | Date | Prescriber Signature – Dispense as Written | Date

I authorize Polaris Specialty Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including submission of any necessary forms to such health plans.