HealthQuest
Infusion & Specialty

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KRYSTEXXA (PEGLOTICASE) INFUSION ORDERS

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

ACHC ACCREDITED

DATE _____ DATE NEEDED _____

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name _____
Patient Address _____
City _____ State _____ Zip _____
Day Phone _____ Work Phone # _____
Cell Phone _____ E-mail _____
Date of Birth _____ SS # _____
☐ Female
☐ Male

Prescriber's Name _____
License # _____ DEA # _____
NPI # _____ UPIN # _____
Practice Name _____
Office Contact _____
Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

DIAGNOSIS

Patient: Wt._____ Ht._____ Allergies: ☐ Latex ☐ Other, specify _____

ICD-10 DIAGNOSIS CODE ☐ J Code: J2507 ☐ Chronic Gouty Arthropathy w/tophus (tophi) [ICD-10 Code: _____]
☐ Chronic Arthopathy w/o mention of tophus (tophi) [ICD-10 Code: _____]

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached
☐ Krystexxa Service Request Form
☐ Baseline Uric Acid level
☐ Normal Glucose-6 phosphate dehydrogenase (G6PD) attached
☐ It is recommended that patients discontinue oral urate-lowering medications before starting Krystexxa
☐ Documentation of frequency and date of flares in last 18 months:

Labs: ☐ Infusion Clinic ☐ Referring Physician
Labs requested: _____

PRESCRIPTION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Krystexxa	☑ 8mg IV in 250mL of NS IV over 120 min* *Patient will be observed 1hr post infusion	☐ Initial dose: 8mg IV in 250mL of NS IV over 120 min ☐ Patient will be observed 1hr post infusion ☐ Frequency: every 2 wks **Protocol Pre-Medication Orders:** Solu-Medrol 125mg IV, Benadryl 25mg PO/IV *Patient advised to take antihistamine day before infusion *Patient must have Uric Acid level drawn 24-72 hours prior to each infusion *Patient must have Glucose-6 phosphate dehydrogenase (G6PD) deficiency screening prior to initiating therapy **Additional Orders/Comments:**	☐ 1 wk. supply ☐ 2 wks. supply	

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) _____ **DATE** _____