# Krystexxa® Referral Form

IVCareOptions

**PHONE: 1-800-277-7302 FAX: 1-866-374-6663**

**Demographics Information**: Today's Date _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Height:_____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____

Allergies: _____ ☐ **NKDA**

**Diagnosis Information**: ☐ M1A.9XX0 Chronic Gout, unspecified site, without mention of tophus(tophi)
☐ M1A.9XX1 Chronic Gout, unspecified site, with mention of tophus(tophi)
☐ Other Diagnosis/ICD10Code_____

Date Infusion to Begin: _____

Previous Infusion Reaction: ☐ YES ☐ NO

List Reactions: _____

Is this a first infusion? ☐ YES ☐ NO

Date of Last Infusion: _____

List of Failed Therapies: _____

**Assessment Questions**: *Please Provide Appropriate Documentation*
Diabetes? ☐ Yes ☐ No HTN? ☐ Yes ☐ No Cardiac History? ☐ Yes ☐ No Difficulty Breathing? ☐ Yes ☐ No
Requires Oxygen? ☐ Yes ☐ No Confusion /Disorientation? ☐ Yes ☐ No Neuro History? ☐ Yes ☐ No
TB status if known: _____ Date of negative G6PD test: _____

**Krystexxa® (Pegloticase): J2507 Baseline SUA level: _____ Date obtained: _____**

☐ SUA level drawn 48-72 hours prior to infusion; 8 mg IV infused over 2 hours every 2 weeks for _____months: Nurse to Administer Methylprednisolone 100mg IV x1 30 minutes prior to infusion
☐ **Verify Gout flare prophylaxis**: _____

**Pre-Medications: Patient to Provide and take 30 minutes prior to infusion**

☐ Benadryl 25 MG PO x1 ☐ Benadryl 50 mg PO x1
☐ Acetaminophen 325 mg PO x1 ☐ Acetaminophen 650 mg PO x1
☐ Other Pre-medication: _____

**Access**: ☐**PIV** ☐ **PORT** ☐ **PICC** **Route:** ☐ **IV**

Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency

PIV – NS 5mL x 10

PORT – NS 10mL x 10, Heparin 5mL 100units/mL x 1 per infusion.

PICC – NS 10mL x 10, Heparin 5mL 10units/mL x 1 per infusion

**Supplies:** (please strike through if not required)

Administration Supplies (A4222) – 2 per infusion

Catheter Care Supplies (A4221) – 1 per week

Infusion Pump (E0781)

Nursing services to administer

***For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures***

Physician/PA signature: _____

NPI # _____ Phone Number _____

Office Address: _____ City: _____ St GA Zip: _____

Printed Name:_____ Contact Name: _____

**Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.**

**01/21 TSP**