

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: <u>GA</u> Zip: _____	
Phone #: _____ <input type="checkbox"/> Cell Alternate Phone #: _____ <input type="checkbox"/> Cell	
Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____	
Allergies: _____ <input type="checkbox"/> NKDA	
Diagnosis Information: <input type="checkbox"/> M1A.9XX0 Chronic Gout, unspecified site, without mention of tophus(tophi) <input type="checkbox"/> M1A.9XX1 Chronic Gout, unspecified site, with mention of tophus(tophi) <input type="checkbox"/> Other Diagnosis/ICD10Code _____	
Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____
Assessment Questions: <i>Please Provide Appropriate Documentation</i> Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No HTN? <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac History? <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No Requires Oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No Confusion /Disorientation? <input type="checkbox"/> Yes <input type="checkbox"/> No Neuro History? <input type="checkbox"/> Yes <input type="checkbox"/> No TB status if known: _____ Date of negative G6PD test: _____	
Krystexxa® (Pegloticase): J2507 Baseline SUA level: _____ Date obtained: _____	
<input type="checkbox"/> 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 <input type="checkbox"/> Verify Gout flare prophylaxis: _____	
Pre-Medications: Patient to Provide and take 30 minutes prior to infusion	
<input type="checkbox"/> Benadryl 25 MG PO x1 <input type="checkbox"/> Benadryl 50 mg PO x1 <input type="checkbox"/> Acetaminophen 325 mg PO x1 <input type="checkbox"/> Acetaminophen 650 mg PO x1 <input type="checkbox"/> Other Pre-medication: _____	
Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency PIV – NS 5ml: Qty 10 PORT – NS 10ml: Qty 10, Heparin 5mL 100units/mL x 1 per infusion. PICC – NS 10ml: Qty 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
<i>For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures</i>	
Physician/PA signature: _____	
NPI # _____ Phone Number _____	
Office Address: _____ City: _____ St <u>GA</u> 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.	