

INFUSION & MEDICAL CENTER

1. _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnosis):

Primary Diagnosis: _____ Chronic Gout ICD-10 Code: M1A.0_____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- G6PD Screening Results (Qualitative)
- Medication list including current gout pharmacologic plan

Patient
Weight: _____ lbs.
Height: _____ in.

Patient to discontinue urate-lowering therapies (e.g. allopurinol, febuxostat, etc.) on _____

Infusion Center – Lab Orders: (Check order for Infusion Center to manage):

Obtain serum uric acid level (sUA) 24-48 hours prior to each infusion

KRYSTEXXA® (pegloticase)

J Code: 2507

4. Drug Order:

Krystexxa 8 mg IV over 2 (two) hours via a pump

Frequency: Administer every 2 (two) weeks _____ # Refills (Recommend 11 Refills)

Pre-Medication Orders:

Acetaminophen 650 mg PO, Diphenhydramine 25 mg PO, and methylprednisolone 125 mg IV
 Administered 30 min prior to infusion *Adjust to patient's needs

Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** _____ / _____ Date: _____
 Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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