Pegloticase (Krystexxa)

Health Redeemer

Provider Order Form Revised 10/30/2025

PROVIDERS: Please include the following information to expedite the order:
Patient Demographic, most recent Office Visit Note, Insurance Information, TB Results, Recent Labs

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date:_____ Patient Name:_____ DOB:_____

ICD-10 code: ☐M1A.0 ☐M1A.3 ☐M1A.4 ☐M1A.9 ☐Other:_____

ICD 10 Description:_____

☐NKDA Allergies:_____Weight (lb/kg)_____ Height:_____

Patient Status: ☐ New to Therapy ☐New to Therapy Last Treatment Date:_____ Next Due Date:_____

PROVIDER INFORMATION

Referral Coordinator Name:_____ Referral Coordinator Email:_____

Ordering Provider:_____ Provider NPI:_____

Referring Practice Name:_____ Phone:_____ Fax:_____

Practice Address:_____ City:_____ State:_____Zip:_____

NURSING

☒ Utilize Hypersensitivity protocol established by Redeemer Health Infusion and PI

☒ Provide nursing care and observation per Redeemer Health Infusion Policies and Procedures

☐ Is there an immunomodulator prescribed? ☐ Yes ☐ No

☐ Methotrexate ☐ Other:_____

It is recommended to start methotrexate with folic acid or folinic acid supplementation at least 4 weeks prior to initiating and throughout treatment.

☐ Have oral urate-lowering medications been discontinued?

☐ Yes ☐ No

It is recommended to discontinue all oral urate-lowering medications prior to starting Krystexxa treatment and not institute therapy with oral urate-lowering medications while patients are currently on Krystexxa therapy.

☒ G6PD Enzyme Activity Level: _____

☒ Baseline Serum Uric Acid Level: _____

LABORATORY ORDERS

☒ **Uric Acid Level** ☐ **2-3 days prior to each infusion**

☐ CBC ☐ at each dose ☐ every_____

☐ CMP ☐ at each dose ☐ every_____

☐ CRP ☐ at each dose ☐ every_____

☐ Other:_____

☐ Please check this box if you do NOT authorize Redeemer Health Infusion to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐500 mg/ ☐650 mg/ ☐1000 mg PO

☐ cetirizine (Zyrtec) 10 mg PO

☐ loratadine (Claritin) 10 mg PO

☒ diphenhydramine (Benadryl) ☐25 mg/ ☐50 mg ☐PO/☐IV

☒ methylprednisolone (Solu-Medrol) ☐ 40 mg/ ☐ 125 mg IV

☐ Other:_____

Dose:_____ Route:_____

Frequency:_____

THERAPY ADMINISTRATION

☒ **Pegloticase (Krystexxa)** intravenous infusion

☒ Dose: 8 mg

☒ Route**:** Intravenous

☒ Rate**:** Infuse over 30 minutes

☐ Frequency**:** ☐ Every 2 weeks / ☐ Other: _____

☐ Infuse over 120 minutes per manufacturer's guidelines

☒ Flush with 0.9% sodium chloride after infusion completion

☒ Patient is required to stay for one hour observation post infusion

☒ Refills: ☐ Zero/ ☐ for 12 months/ ☐ Other:_____

(If not indicated, order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Redeemer Infusion is authorized to administer a generic or biosimilar.

SPECIAL INSTRUCTIONS

☐ Please check this box if you DO NOT authorize Redeemer Infusion to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

_____ _____ _____

Provider Name (Print) Provider Signature Date