Krystexxa® Provider Order Form

Please fax completed referral order form & all required documents to **281-295-4051**

AguaVivir
www.aguavivir.com

PATIENT DEMOGRAPHICS

Patient Name: ______________________ DOB: ______________ Phone: ______________

Address: ______________________ City/ST/Zip: ______________________

Allergies: ______________________ ☐ NKDA Weight: ________ ☐ lbs ☐ kg Height: ________ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

****ICD 10 Code Required***

☐ Idiopathic chronic gout (M1A.00-M1A.09), ICD10 __________

☐ Lead-induced chronic gout (M1A.10-M1A.19), ICD10 __________

☐ Drug-induced chronic gout (M1A.20-M1A.29), ICD10 __________

☐ Other: ______________________, ICD10 __________

☐ Chronic gout due to renal impairment (M1A.30-M1A.39), ICD10 __________

☐ Other secondary chronic gout (M1A.40-M1A.49), ICD10 __________

☐ Chronic gout, unspecified (M1A.9XX0-M1A.9XX1), ICD10 __________

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Krystexxa® (Pegloticase)	8 mg	Infuse IV over 2 hours once every 2 weeks x 1 year ☐ Notify physician if uric acid >6 mg/mL before infusing ☐ Observe patient for 1 hour after completion of infusion

Is patient currently receiving therapy above from another facility?

☐ NO ☐ YES

If yes, Facility Name: ______________________

Date of last treatment: ______________ Date of next treatment: ______________

PRE-MEDICATION ORDERS

- Acetaminophen 650mg PO 30 minutes prior to infusion
- Diphenhydramine 25mg/50mg PO 30 minutes prior to infusion
- Methylprednisolone 100mg IV 30 minutes prior to infusion

☐ Other: ______________________

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ Serum uric acid – baseline and prior to each infusion with results

☐ Other: ______________________

REFERRING PHYSICIAN INFORMATION

Physician Signature: ______________________ Date: ______________

Physician Name: ______________ Provider NPI: ______________ Specialty: ______________

Address: ______________________ City/ST/Zip: ______________________

Contact Person: ______________ Phone #: ______________ Fax #: ______________

Email Where Follow Up Documentation Should Be Sent: ______________________

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

☐ Yes ☐ No Has the patient been screened for Glucose-6-phosphate dehydrogenase (G6PD) deficiency?

☐ Yes ☐ No Does the patient have refractory chronic gout as evidenced by the following?

☐ History of at least 3 gout flares in the previous 18 months

☐ At least 1 gout tophus

☐ Gouty arthritis

☐ Other: ______________________

LAB and TEST RESULTS (required)

☐ Baseline serum uric acid level

☐ Glucose-6-phosphate dehydrogenase (G6PD)

☐ Other: ______________________

PRIOR FAILED THERAPIES FOR CHRONIC GOUT

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________

Medication Failed: ______________ Dates of Treatment: ______________ Reason for D/C: ______________