Krystexxa Prescription / Enrollment Form Date: _____	Y Medical Associates Fax Referral To: 855-838-0623 Phone: 800-447-7558	YMedical ASSOCIATES

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____ Gender: ☐ M ☐ F

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA#: _____ NPI#: _____
Contact Person: _____

INSURANCE INFORMATION *(Please attach the front and back of insurance and prescription drug card)*

Primary Insurance: _____ ID#: _____ Group: _____
Secondary Insurance: _____ ID#: _____ Group: _____
Prescription Card: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____

DIAGNOSIS (ICD-10)

☐ M1A9XX0 Chronic Gout, unspecified, without tophus (tophi)
☐ M1A9XX1 Chronic Gout, unspecified, with tophus (tophi)
☐ Yes ☐ No: Does the patient have a diagnosis of asymptomatic hyperuricemia or a deficiency in G6PD?
If yes, **patient is not a candidate for Krystexxa.**

PRE-SCREENING

Please include most recent clinical notes and lab results for the following:

☐ G6PD Deficiency Test (to rule out Hemolysis and Methemoglobinemia)
☐ Baseline Serum Uric Acid Levels: Draw labs 24-72 hours prior to the infusion.
☐ Pre-existing conditions: Monitor patients with CHF/MI closely, if applicable.
☐ Yes ☐ No: Will oral urate-lowering treatments be discontinued before starting Krystexxa?

PRESCRIPTION ORDERS

Premeds

Premedication to be given 30 minutes prior to infusion:

☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg
☐ Diphenhydramine: ☐ 25mg IVP ☐ 50mg IVP ☐ 25mg PO ☐ 50mg PO **OR** ☐ Alternate oral antihistamine: ☐ Cetirizine 10mg ☐ Loratadine 10mg
☐ Methylprednisolone ☐ 125mg IVP ☐ 40mg IVP OR ☐ ____mg PO ☐ Fexofenadine 60mgs ☐ Fexofenadine 180mgs

☐ Others/Miscellaneous: _____

☐ Epinephrine pen Auto-Injector 2 pack 0.3mg/0.3ml IM as needed for anaphylaxis

Medication

☐ Krystexxa (Pegloticase) 8mg in 250ml Sodium Chloride 0.9% Solution IV over not less than 2 hours via pump every 2 weeks, followed by one hour post infusion monitoring after each dose.
Flushing Protocol:
☐ NaCl 0.9% 5-10ml IV before and after infusion
☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral/PICC access and PRN
☐ Heparin 100units/m 3-5ml IV after infusion for Port IV access and PRN
☐ All infusion supplies necessary to administer the medication
Skilled nurse to assess, teach, and administer prescribed medication and admit for services.
☐ Home ☐ Infusion Suite ☐ MD Office
To be infused at physician's office / infusion suite / patient's home under close supervision of a healthcare professional

By signing below, I certify that above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

_____ _____ _____ _____
Dispense as Written Date Substitution Allowed Date