Krystexxa Prescription/Enrollment Form	Century Specialty Script Fax Referral To: 877-521-5353	
Date: _____	Phone: 800-521-3949	

Patient Information

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
DOB: _____ 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)

☐ M1A.9XX0 Chronic Gout, unspecified, without tophus (tophi)
☐ M1A.9XX1 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:
☐ 6PD Deficiency Test (to rule out Hemolysis and Methemoglobinemia)
☐ Baseline Serum Uric Acid Levels: (more than 6mg/dl) 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 Order

Premedications

Premedication can be given 30 minutes prior to infusion:
☐ Acetaminophen PO: ☐ 325mg ☐ 500mg ☐ 650mg
☐ Diphenydramine: ☐ 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 Ptotocol:
☐ 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 100 units/ml 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.

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

_____ _____ _____ _____
Dispense as Written **Date** **Substitution Allowed** **Date**