

Checklist for Krystexxa (pegloticase) Referral

Required documentation for all initial referrals

Patient _____ DOB _____ Date _____ New Start Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- Patient demographics (e.g. address, phone number, SSN, etc.)
- Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber’s date of birth.
 - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- Signed and completed Krystexxa Standard Order (our order form) with ICD diagnosis code
 - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Krystexxa.
- Lab results and/or tests to support diagnosis.
 - Pre-Screening:
 - **Required G6PD results**
 - **Lab results within last 14 days:** CBC with diff, CMP (to include ANC, AST & ALT) and Uric Acid every two weeks. *Serum Uric Acid level approximately 24-48 hours prior to each infusion.*
- Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
 - Name: _____
 - Phone Number: _____

Paperwork can be faxed to (843)-793-6181

Infusion Coordinators can assist you with any questions at
(843)-572-8932

Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

Summerville

2001 2nd Ave, Suite 201, Summerville, SC 29486

Mount Pleasant

1100 Johnnie Dodds Blvd, Mt. Pleasant, SC 29464

West Ashley

2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our NP to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Low Country Rheumatology Use Only Existing Patient Yes ___ No ___ Physician _____

Patient _____ DOB _____ Date _____

Indication:

<input type="checkbox"/> M10.00 Gouty arthropathy, unspecified	<input type="checkbox"/> M10.00 Acute gouty arthropathy, including acute gout and flare	<input type="checkbox"/> Other _____
--	---	--------------------------------------

History:

- Has the patient had failure, intolerance, or contraindication to conventional therapy? Yes No
- If yes, please specify treatment/medication tried and outcomes:

- Has the patient stopped taking any oral urate-lowering therapy? Yes No
- Is the patient G6PD deficient? Yes No

Orders:

Standard Order Protocol:

- Obtain patient weight each visit
- Baseline vitals will be obtained prior to administration, hourly during infusion and the 1 hour post infusion observation period, and prior to discharge home. Vital signs will be obtained more frequently if patient’s condition warrants it.
- Instruct patient/caregiver on medications, signs/symptoms of adverse reaction.
- Assess patient for response to therapy.
- Infuse over 120 minutes.
- **If infusion reaction occurs, slow or stop infusion, and initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
- Observe patient 60 minutes after completion of infusion for adverse reaction.
- Discharge instructions to include possible infusion side effects and follow-up appointment schedule.

Dose:

Standard Dose Protocol:

- Krystexxa 8mg infused in 250mL in Normal Saline over 2 hours.
- Orders to be completed every 2 weeks.

Other:

Serum Uric Acid level approximately 24-48 hours prior to each infusion – hold infusion if 2 consecutive levels are above 6mg/dl. If patient misses 2 doses (4 weeks) resuming treatment must be cleared by ordering physician or therapy discontinued.

Premedicate:

Per package insert, pre-medicate x 1 dose 30 minutes prior to each infusion with:

- 1000 mg Acetaminophen PO 25mg Benadryl IV 125mg Solu-Medrol IV Other_____

Additional orders/comments:

Practice Name: _____

NPI: _____

Physician Name: _____

State License: _____

Physician Signature: _____

DEA #: _____

Date: _____

UPIN: _____