



Fax To: (877) 428-1627
 Email To: referrals@curbsideinfusion.com
 Office: (877) 428-7248

KRYSTEXXA® (PEGLOTICASE) ORDER FORM

REFERRAL STATUS

New Referral
 Order Renewal
 Restart
 Medication/Order Change
 Benefits Verification Only
 _____ D/C Infusion (Medication(s) to D/C _____)

PATIENT INFORMATION

PATIENT NAME:		DOB:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ADDRESS:		PHONE #:	
WEIGHT: _____ LBS _____ KG	HEIGHT:		EMAIL:
ALLERGIES:			
Please check that the following are included	<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	<input type="checkbox"/> Current Medication List		<input type="checkbox"/> G6PD
	<input type="checkbox"/> Baseline Uric Acid > 6.0mg/dl		

PHYSICIAN INFORMATION

Physician Name:	Email (if you would like referral updates):
Practice Name:	Phone Number:
Office Contact:	Fax Number:

DIAGNOSIS

<input type="checkbox"/> Chronic Gouty Arthropathy w/ Tophus (tophi)	<input type="checkbox"/> Chronic Gouty Arthropathy w/out Tophus (tophi)	<input type="checkbox"/> Other:

ICD-10 CODE:	Date of last infusion/injection:
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MEDICATION ORDERS

KRYSTEXXA ORDERS: Dose: 8 mg/mL IV in 250mL bag of 0.9% or 0.45%NaCl every 2 weeks PreMedications *protect from light and use within 4 hours of mixing IV Corticosteroids: Methylprednisolone hydricortisone 125mg prior to each infusion. Antihistamines: Allegra 180mg; Claritin 10mg; Benadryl 25-50mg po to be taken night before infusion and/or can administer concomitant with infusion. Oral Analgesic: Tylenol 325mg 2 po prior to each infusion. Administration Administer IV infusion over at least 2 hr via gravity feed or volumetric infusion pump	Notes/Comments
Physician Signature _____ Date (Order is Valid for One Year) _____ Infusion will be administered per Curbside Infusion Venture policy and protocol.	

STANDING LAB ORDERS

<input type="checkbox"/> Labs to be Drawn by Infusion Center	Frequency: <input type="checkbox"/> Every Infusion <input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> CMP <input type="checkbox"/> CBC <input type="checkbox"/> CRP <input type="checkbox"/> ESRP <input type="checkbox"/> HFR <input type="checkbox"/> UA	

In the event of anaphylaxis and infusion reaction, the infusion should be slowed, or stopped and restarted at a slower rate. Inform patient of signs and symptoms of anaphylaxis.
 Standing Anaphylaxis Protocol