SPECIALTY INFUSION CENTER
An Access Infusion Care Company

PEGLOTICASE ORDERS (Krystexxa)

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST

Please ensure the following information is included with your referral:

- ☐ Patient Demographics and Contact Information
- ☐ Patient Insurance Information
- ☐ Completed H&P and Progress Notes Including Medications and Allergies
- ☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
- ☐ Xray Reports Indicating Joint Damage from Gout
- ☐ Completed and Signed Referral
- ☐ Baseline Uric Acid Level, G6PD Screening
- ☐ Arrangements for Uric Acid Level lab Prior to Each Administration
- ☐ Completed and Signed Referral

Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient.
Thank you!

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Print, complete, and fax completed form to (855) 857-3834

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Height: Weight: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change	
First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS	
☐ M1A.00X0: Chronic gout with Tophus (Idiopathic)	Other Dx Code and description:

REQUIRED DOCUMENTATION	
☐ This signed order ☐ Patient demographics and insurance information ☐ H&P, labs, tests, progress notes supporting diagnosis	
• Prior Therapies:	☐ Negative G6PD screening – attach results
Methotrexate/folic acid supplementation start date: ☐ N/A-monotherapy	☐ Baseline Uric Acid Level (attach results):
☐ Patient has a standing Uric acid level lab order for 48 hours prior to each infusion. Will hold if >6mg/dL for two consecutive infusions.	

PRESCRIBING INFORMATION

LAB ORDERS

Frequency:Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ ☐ Uric Acid level prior to each infusion

PREMEDICATIONS (administer 30 minutes prior to infusion, recommended by manufacturer)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒ **Pegloticase (Krystexxa)**	8mg/mL	☒ 8mg Infuse in 250ml 0.9%NS IV over 120 minutes every 2 weeks	1 vial Refills:

If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 60 minutes after the infusion.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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