Pegloticase (Krystexxa)

Provider Order Form *rev. 11/23/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Documentation of initiation of Methotrexate and folic acid • Serum uric acid level within 1 month for initiation of therapy

• Glucose-6-phosphate dehydrogenase (G6PD) results and date

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ M1A.9xx0 Chronic gout, unspecified, without tophi ☐ M1A.9xx1 Chronic gout, unspecified, with tophi

☐ Other:

REQUIRED DOCUMENTATION

- Has patient experienced at least 2 gout flares in previous 18 months? ☐ Yes ☐ No
- Has patient stopped taking oral urate-lowering therapy? ☐ Yes ☐ No
- Serum Uric Acid Level:_____ Date Drawn:_____
- G6PD Results:_____ Date Drawn:_____
- Arbor Infusion will manage the standing uric acid order unless you opt out: ☐ Opt Out (I will manage the standing uric acid order)

PRIMARY MEDICATION ORDER

Pegloticase (Krystexxa) 8mg IV every 2 weeks

- Infuse over 120 minutes per manufacturer's guidelines
- Flush with 0.9% sodium chloride at the completion of infusion
- Patient is required to stay for one-hour observation period
- Refill for 12 months unless otherwise noted:_____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: Recommendations per PI are selected, these will be given to patient unless otherwise specified.

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☑ diphenhydramine (Benadryl) ☑ 25mg / ☐ 50mg ☑ PO / ☐ IV

☑ methylprednisolone (Solu-Medrol) ☐ 40mg / ☑ 125mg IV

☐ Other:_____

Dose:_____ Route:_____

LABORATORY ORDERS

☑ Uric acid prior to each dose

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other:_____

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

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