

Pegloticase (Krystexxa)

Provider Order Form rev. 8/25/26



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)*

- ☐ Arbor Infusion Fishers (317) 981-1772