MIC | METRO INFUSION CENTER

MEDICATION ORDERS-KRYSTEXXA (PEGLOTICASE)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Chronic Gout	ICD 10 Code: M1A

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ Uric acid level	☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis ☐ G6PD test results
List Tried & Failed Therapies: 1) 2) 3)	

MEDICATION ORDERS	
Dosing	☐ Krystexxa 8mg IV every 2 weeks
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PREMEDICATIONS
☐ Acetaminophen 650mg PO prior to Krystexxa infusion
☐ Diphenhydramine 25mg PO prior to Krystexxa infusion
☐ Methylprednisolone 40mg Slow IV Push prior to Krystexxa infusion
☐ Other:

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.

PRESCIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164