Pegloticase (Krystexxa)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Gouty arthropathy:

Other: Description:

REQUIRED INFORMATION

☑ G6PD Results _____

☑ Baseline uric acid level _____ & date _____

THERAPY ADMINISTRATION & DOSING

☐ Krystexxa 8mg IV every 2 weeks with weekly oral methotrexate 15mg and daily folic acid 1mg[1]

☐ Methotrexate contraindicated and patient is on Krystexxa Monotherapy 8mg IV every 2 weeks

☑ Monitor patient for hypersensitivity reaction for a period of 60 minutes following each infusion

[1]Begin weekly Methotrexate and Folic Acid 4 weeks prior to the start of Krystexxa infusions.

FREQUENCY *(Choose one)*

☐ Every 2 weeks

☐ Other: _____

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ Obtain serum uric acid level prior to each infusion (or may use result obtained within 48 hrs prior to infusion).

☐ Other: _____

PRE-MEDICATION ORDERS

☑ All premedication administered 30mins prior to infusion

☐ Loratadine 10mg PO

☐ Tylenol 500mg PO

☐ Solumedrol 125mg IV

☑ Benadryl ☐ 25 mg / ☐ 50mg ☐ PO / ☐ IV ***(must have per PI)***

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Uric acid level greater than 6 mg/dL for 2 consecutive treatments (lab orders below).
- Patient has had more than 4 weeks between treatments (due to increased risk for adverse reaction).
- Patient reports continued use of uric acid lowering agents (allopurinol, febuxostat, probenecid, etc.)
- Hypertension (170/90 or symptomatic)

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with colchicine, NSAIDs, steroids, Febuxostat, Allopurinol, Probenecid. flares in 12 months, Gouty arthritis, Tophus **Required Labs:** G6PD, UA level, CRP/ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.