

# Krystexxa® (pegloticase) Referral Form



**Patient Preferred Clinic** (select one):

## PATIENT INFORMATION

### Referral Status:

New Referral

Updated Order

Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:		Weight (lbs/kg):	Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

## NURSING

Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

CBC At each dose Every \_\_\_\_\_  
CMP At each dose Every \_\_\_\_\_  
CRP At each dose Every \_\_\_\_\_

### URIC ACID PRIOR TO EACH INFUSION

Standing Uric Acid order to be placed by referring office

Standing Uric Acid order to be placed by Vivo Infusion

## PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO  
cetirizine (Zyrtec) 10mg PO  
loratadine (Claritin) 10mg PO  
diphenhydramine (Benadryl) 25 mg 50 mg PO IV  
methylprednisolone (Solu-Medrol) 40mg 125mg IV  
hydrocortisone (Solu-Cortef) 100mg IV  
Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## KRYSTEXXA THERAPY ADMINISTRATION

8 mg IV every 2 weeks

Patient will be on methotrexate or other immunomodulation therapy.  
*\*\*Product information suggests co-administration of 15 mg weekly of methotrexate and folic acid therapy if not contraindicated. If co-administering methotrexate, start weekly methotrexate and folic acid or folic acid supplementation at least 4 weeks prior to initiation, and throughout treatment with Krystexxa.\*\**

## REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

G6PD

Baseline Uric Acid >6.0mg/ds

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. \*\*Order is valid for one year unless otherwise noted\*\*

Provider Name (Print)

Provider Signature

Date

## Fax Numbers

Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: [referrals@vivoinfusion.com](mailto:referrals@vivoinfusion.com)

Email Specialty Referrals to:  
[info@specialtyinfusion.com](mailto:info@specialtyinfusion.com)

Revision Date 5/2024