# Krystexxa® (pegloticase) Referral Form

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

VIVO infusion®

**PATIENT INFORMATION**

**Referral Status:** ☐ New Referral ☐ Updated Referral ☐ Referral 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 Digits SSN:

**PROVIDER INFORMATION**

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

**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 folinic 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**

**Email Referrals To: referrals@vivoinfusion.com OR Fax Below**

**Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679
Connecticut: 203-724-4838
Florida: 904-930-4211
Massachusetts: 781-202-1629
Michigan: 833-957-2188
Minnesota: 763-290-0903
Nevada: 702-489-5744
New Jersey: 609-955-3711
New York: 800-540-1852
Ohio: 216-400-0674
Oklahoma: 918-770-4421
Pennsylvania: 215-399-9244
Texas: 469-340-0044
Virginia: 804-500-5941
Wisconsin: 414-600-5383

Revision Date 5/2025