

Krystexxa® (pegloticase) Referral Form



Preferred Clinic (select one):

PATIENT INFORMATION

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 Infusion 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:

STANDING ORDERS

Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC w/ diff every _____
CMP every _____
OTHER _____
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) 500mg 650mg 1000mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

KRYSTEXXA 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.****

Post Infusion: Flush with tubing volume

REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card/Information
- Progress Notes Supporting DX
- Current Medication List and H&P
- G6PD
- Baseline Uric Acid >6.0mg/ds
- Patient will discontinue urate-lowering therapy prior to initiation of Krystexxa

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

Order is valid for one year unless otherwise noted.

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