

### Checklist for Krystexxa (pegloticase) Referral

Required documentation for all initial referrals

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_  New Start  Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- Patient demographics (e.g. address, phone number, SSN, etc.)
- Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber’s date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- Signed and completed Krystexxa Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at [lowcountryrheumatology.com/infusions/](http://lowcountryrheumatology.com/infusions/)*
- Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Krystexxa.
- Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required TB screening results:** PPD (*within 1 year*) or QuantiFERON Gold Test (*within 3 years*)
    - **Required Hepatitis screening (*within 1 year*):** Hepatitis B Surface Antigen, Hepatitis B Surface Antibody, and Hepatitis B Core Antibody results
    - **Lab results within last 14 days:** CBC with diff, CMP (to include ANC, AST & ALT) and Uric Acid every two weeks. *Serum Uric Acid level approximately 24-48 hours prior to each infusion.*
    - **Most recent Rapid 3 (if available)**
- Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: \_\_\_\_\_
  - Phone Number: \_\_\_\_\_

**Paperwork can be faxed or emailed to (843)-824-2327, [infusionemail@articularishealthcare.com](mailto:infusionemail@articularishealthcare.com)**

Infusion Coordinators Brenna, Carlye or Stephanie will assist you with any questions at (843)-572-8932

#### Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

#### Summerville

2001 2nd Ave, Suite 201, Summerville, SC 29486

#### Mount Pleasant

1165 Chuck Dawley Blvd, Mt. Pleasant, SC 29464

#### West Ashley

2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our NP to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

**Low Country Rheumatology Use Only** Existing Patient Yes \_\_\_ No \_\_\_ Physician \_\_\_\_\_

## Standard Orders for Krystexxa (pegloticase) Administration

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Indication:**

<input type="checkbox"/> M10.00 Gouty arthropathy, unspecified	<input type="checkbox"/> M10.00 Acute gouty arthropathy, including acute gout and flare	<input type="checkbox"/> Other _____
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**History:**

- Has the patient had failure, intolerance, or contraindication to conventional therapy?  Yes  No
- If yes, please specify treatment/medication tried and outcomes: \_\_\_\_\_

- Has the patient stopped taking any oral urate-lowering therapy?  Yes  No
- Is the patient G6PD deficient?  Yes  No

**Orders:**

- Standard Order Protocol:
  - Obtain patient weight each visit
  - Vital signs every 30 minutes beginning with the start of infusion and 30 minutes after infusion is complete.
  - Instruct patient/caregiver on medications, signs/symptoms of adverse reaction.
  - Assess patient for response to therapy.
  - Infuse over 120 minutes.
  - **If infusion reaction occurs, slow or stop infusion, and initiate infusion reaction protocol per Articularis Healthcare Policy and Procedure Manual.**
  - Observe patient 60 minutes after completion of infusion for adverse reaction.
  - Discharge instructions to include possible infusion side effects and follow-up appointment schedule.

**Dose:**

- Standard Dose Protocol:
- Krystexxa 8mg infused in 250mL in Normal Saline over 2 hours.
  - Orders to be completed every 2 weeks.

**Other:**

Serum Uric Acid level approximately 24-48 hours prior to each infusion – hold infusion if 2 consecutive levels are above 6mg/dl. If patient misses 2 doses (4 weeks) resuming treatment must be cleared by ordering physician or therapy discontinued.

**Premedicate:**

Per package insert, pre-medicate x 1 dose 30 minutes prior to each infusion with:  
 1000 mg Acetaminophen PO     25mg Benadryl IV     125mg Solu-Medrol IV    Other \_\_\_\_\_

**Additional orders/comments:**

\_\_\_\_\_  
\_\_\_\_\_

Practice Name: \_\_\_\_\_

NPI: \_\_\_\_\_

Physician Name: \_\_\_\_\_

State License: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

DEA #: \_\_\_\_\_

Date: \_\_\_\_\_

UPIN: \_\_\_\_\_