KRYSTEXXA™ Infusion

OptiMed
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Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐M ☐F

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐lb ☐kg **Height:** _____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose? ☐Yes ☐No; date of last dose _____ **Prior infusion reactions:** _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

REQUIRED **G6PD deficiency:** ☐Yes ☐No **Latest serum uric acid (sUA):** _____ _____

Prescriber is responsible for ensuring the patient has orders for pre-infusion serum uric acid to be drawn within 48 hours prior to each Krystexxa™ infusion.^ For streamlined communications, please request the lab to share results with OptiMed.

^If sUA level is > 6mg/dL, consider discontinuing treatment, particularly when two consecutive sUA levels > 6mg/dL are observed.

Patient on gout flare prophylaxis? ☐Yes ☐No*; If yes, medication and dose: _____

*If no, it is recommended starting at least 1 week before initiation of KRYSTEXXA therapy and lasting at least 6 months.

Prescription Information

Krystexxa™ Dosing Regimen	Quantity
☐ **Dosing:** Infuse Krystexxa™ 8mg in 250mL NaCl 0.9% IV every 2 weeks, infused over no less than 2 hours (Infuse rate not to exceed 125mL/h)* *If serum uric acid > 6mg/dL after first infusion of Krystexxa™, hold dosing unless explicit consent is received from the ordering provider to continue treatment.	_____ doses (infusions)

Nursing and Supplies: OptiMed to provide additional supply items and nursing care to prepare and administer product as per package instructions.

Premedication(s):

- Methylprednisolone 80mg IV 30 minutes prior to Krystexxa™ infusion
- Acetaminophen 1000mg PO 30 minutes prior to Krystexxa™ infusion
- Diphenhydramine 50mg IV 30 minutes prior to Krystexxa™ infusion

Additional premedication(s): _____

PRN medication orders: _____

Post-Infusion: Patient to receive post-infusion monitoring and hydration with 500mL NaCl 0.9% infused over 60 minutes following each Krystexxa™ infusion.

Lab orders: List any additional outpatient laboratory work related to this therapy you would like OptiMed to draw in conjunction with the patient's medication administration, including the frequency for each lab order. (Lab orders are subject to availability.)

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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CLEAR FORM