Krystexxa® (pegloticase) Referral Form

Patient Preferred Clinic (select one):

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:

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

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